First Health Services Corporation
A Coventry Health Care Company

Claims Resolution

VaMMIS Procedure Manual

Version 1.0

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HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	02/01/2008	[redacted], Documentation Mgmt. Team	Creation of document

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Preface

The Procedures Manual for the Virginia Medicaid Management Information System (VaMMIS) is a product of First Health Services Corporation. Individual manuals comprise the series of documents developed for the operational areas of the VaMMIS project. Each document includes an introduction, a functional overview of the operations area, workflow diagrams illustrating the processing required to accomplish each task, and descriptions of relevant inputs and outputs. Where appropriate, decision tables, lists, equipment operating instructions, etc. are presented as exhibits, which can be photocopied and posted at unit workstations. Relevant appendices containing information too complex and/or lengthy to be presented within a document section are included at the end of the document.

Use and Maintenance of this Manual

The procedures contained in this manual define day-to-day tasks and activities for the specified operations area(s). These procedures are based on First Health's basic MMIS Operating System modified by the specific constraints and requirements of the Virginia MMIS operating environment. They can be used for training as well as a source of reference for resolution of daily problems and issues encountered.

The unit manager is responsible for maintaining the manual such that its contents are current and useful at all times. A hardcopy of the manual is retained in the unit for reference and documentation purposes. The manual is also available on-line for quick reference, and users are encouraged to use the on-line manual. Both management and supervisory staff are responsible for ensuring that all operating personnel adhere to the policies and procedures outlined in this manual.

Manual Revisions

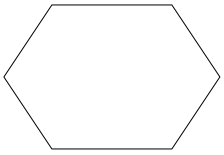
The unit manager and supervisory staff review the manual once each quarter. Review results are recorded on the Manual Review and Update Log maintained in this section of the document. Based on this review, the unit manager and supervisory staff determine what changes, if any, are necessary. The unit manager makes revisions as applicable, and submits them to the Executive Account Manager for review and approval. All changes must be approved by the Executive Account Manager prior to insertion in the manual. When the changes have been approved, the changes are incorporated into the on-line manual. Revised material is noted as such to the left of the affected section of the documentation, and the effective date of the change appears directly below. A hardcopy of the revised pages are inserted into the unit manual, and copies of the revised pages are forwarded to all personnel listed on the Manual Distribution List maintained in this section of the manual.

Flowchart Standards

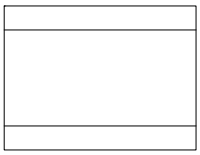
The workflow diagrams included in this document were generated through the flowcharting software product Visio Professional. Descriptions of the basic flowcharting symbols used in the VaMMIS documentation are presented below.

Large Processing Function

Manual Process. No automated processes are used; e.g., clerical function.

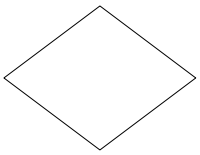


Data Preparation Processing; e.g., mailroom, computer operations, etc.

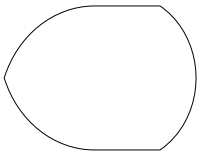


Create a Request

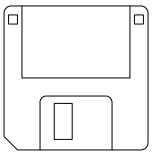
Data maintained in a master datastore.



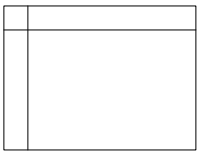
Decision



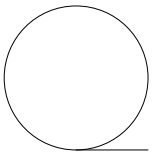
Information entered or displayed on-line.



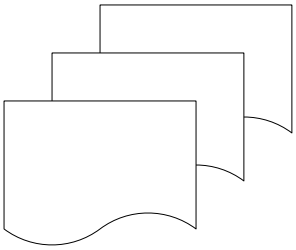
Data stored on diskette media.



On-line Storage; e.g., CD-ROM, microform, imaged data, etc.

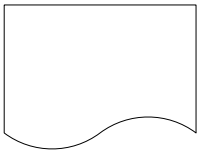


Input or Output Tape



Multiple Outputs; e.g., letters, reports

Communication Link



Single Output; e.g., letter, report, form, etc.

External Entity. Source of entry or exit from a process.

Off-page Connector

1.0 Overview of the Virginia Medical Assistance Program

The Commonwealth of Virginia State Plan under Title XIX of the Social Security Act sets forth the Commonwealth's plan for managing the Virginia Medical Assistance Program (VMAP). It defines and describes the provisions for: administration of Medical Assistance services; covered groups and agencies responsible for eligibility determination; conditions of and requirements for eligibility; the amount, duration, and scope of services; the standards established and methods used for utilization control, the methods and standards for establishing payments, procedures for eligibility appeals; and waivered services.

1.1 Standard Abbreviations for Subsystem Components

For brevity, subsystem components use these abbreviations as part of their nomenclature.

Abbreviation	Subsystem
AM	Automated Mailing
AS	Assessment (Financial Subsystem)
CP	Claims Processing
DA	Drug Application
EP	EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
FN	Financial Subsystem
MC	Managed Care (Financial Subsystem)
MR	MARs (Management and Reporting)
POS	Point of Sale (Drug Application)
PS	Provider
RF	Reference
RS	Recipient
SU	SURS (Surveillance Utilization and Review)
TP	TPL (Financial Subsystem)

1.2 Covered Services

The Virginia Medical Assistance Program covers all services required by Federal legislation and provides certain optional benefits, as well. Services are offered to Medicaid Categorically Needy and Medically Needy clients. In addition, certain services are provided to eligibles of the State and Local Hospitalization (SLH) program and the Indigent Health Care (IHC) Trust Fund. SLH, Temporary Detention Orders (TDO), and IHC are State and locally funded programs with no Federal matching funds. SLH is a program for persons who are poor, but not eligible for Medicaid in Virginia, which is funded by the Commonwealth and local counties.

Services and supplies that are reimbursable under Medicaid include, but are not limited to:

- Inpatient acute hospital
- Outpatient hospital
- Inpatient mental health
- Nursing facility
- Skilled nursing facility (SNF) for patients under 21 years of age
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Hospice
- Physician
- Pharmacy
- Laboratory and X-ray
- Clinic
- Community mental health
- Dental
- Podiatry
- Nurse practitioner
- Nurse midwife
- Optometry
- Home health
- Durable medical equipment (DME)
- Medical supplies
- Medical transportation
- Ambulatory surgical center.

Many of the services provided by DMAS require a co-payment to be paid by the recipient. This payment differs by type of service being billed, according to the State Plan. Payment made to providers is the net of this amount.

General exclusions from the Medicaid Program benefits include all services, which are experimental in nature, cosmetic procedures, acupuncture, autopsy examination, and missed appointments. In addition, there are benefit limitations for specific service categories that must be enforced during payment request processing.

1.3 Waivers and Special Programs

In addition to the standard Medicaid benefit package, the Commonwealth has several Federal waivers in effect which provide additional services not ordinarily covered by Medicaid, as well as special programs for pregnant women and poor children. The programs include:

- **Elderly and Disabled** is a Home and Community Based Care (HCBC) waiver program covering individuals who meet the nursing facility level-of-care criteria and who are at risk for institutionalization. In order to forestall institutional placement, coverage is provided for:
  - Personal Care (implemented 1982)
  - Adult Day Health Care (implemented 1989)
  - Respite Care (implemented 1989)
- **Technology Assisted Waiver for Ventilator Dependent Children** is a HCBC waiver implemented in 1988 to provide in-home care for persons under 21, who are dependent upon technological support and need substantial ongoing nursing care, and would otherwise require hospitalization. The program has since been expanded to provide services to individuals over age 21.
- **Mental Retardation Waiver** includes two HCBC waivers that were implemented in 1991 for the provision of home and community based care to mentally retarded clients. They include an OBRA waiver for persons coming from a nursing facility who would otherwise be placed in an ICF/MR, and a community waiver for persons coming from an ICF/MR or community. The Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) updates the eligibility file for Mental Retardation Waivers.
- **AIDS/HIV Waiver** is a HCBC waiver implemented in 1991 that provides for home and community based care to individuals with AIDS, or who are HIV positive, and at risk for institutionalization.
- **Assisted Living Services** include two levels of payment, regular and intensive. Regular assisted living payments (per day per eligible recipient) are made from state funds. Intensive assisted living payments (per day per eligible recipient) are covered under an HCBC waiver and are made from a combination of state and federal funds.

- **Adult Care Resident Annual Reassessment and Targeted Case Management** provides for re-authorization and/or follow-up for individuals residing in assisted living facilities. The program includes a short assessment process for individuals who are assessed at the residential level and a full assessment for individuals who are assessed at the regular or intensive assisted living level. The targeted case management is provided to individuals who need assistance with the coordination of services at a level which exceeds that provided by the facility staff.
- **PACE/Pre-PACE Programs** provide coordination and continuity of preventive health services and other medical care, including acute care, long term care and emergency care under a capitated rate.
- **Consumer-Directed Personal Attendant Services** is a HCBC waiver that serves individuals who are in need of a cost-effective alternative to nursing facility placement and who have the cognitive ability to manage their own care and caregiver.
- **MEDALLION Managed Care Waiver** is a primary care physician case management program. Each recipient is assigned a primary care physician who is responsible for managing all patient care, provides primary care, and makes referrals. The primary care physician receives fees for the services provided plus a monthly case management fee per patient.
- **MEDALLION II Managed Care Waiver** is a fully capitated, mandatory managed care program operating in various regions of the State. Recipients choose among participating HMOs, which provide all medical care, with a few exceptions.
- ***Options*** is an alternative to MEDALLION where services are provided through network providers, and the participating HMOs receive a monthly rate based on estimated Medicaid expenditures.
- **Client Medical Management (CMM)** is the recipient "lock-in" program for recipients who have been identified as over utilizing services or otherwise abusing the Program. These recipients may be restricted to specific physicians and pharmacies. A provider who is not the designated physician or pharmacy can be reimbursed for services only in case of an emergency, written referral from the designated physician, or other services not included with CMM restrictions. The need for continued monitoring is reviewed every eighteen (18) months. The services not applicable to CMM are renal dialysis, routine vision care, Baby Care, waivers, mental health services, and prosthetics.
- **Baby Care Program** provides case management, prenatal group patient education, nutrition counseling services, and homemaker services for pregnant women, and care coordination for high risk pregnant women and infants up to age two.

1.4 Eligibility

Medicaid services are to be provided by eligible providers to eligible recipients. Eligible recipients are those who have applied for and have been determined to meet the income and other requirements for the Department of Medical Assistance Services (DMAS) services under Medicaid. Virginia also allows certain Social Security Income (SSI) recipients to "spend down" their income to Medicaid eligibility levels by making periodic payments to providers.

Virginia is a Section 209(b) state, meaning that the DMAS administers Medicaid eligibility for SSI eligibles and State supplement recipients locally through the Department of Social Services (DSS). DSS administers eligibility determination at its local offices and is responsible for determining Medicaid eligibility of Temporary Assistance to Needy Families with Children (TANF), Low-Income Families with Children (LIFC), and the aged. DSS also determines financial eligibility of blind and disabled applicants. In addition, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) administers recipient eligibility for Mental Retardation Waivers. The Department of Visually Handicapped (DVH) and the Department of Rehabilitative Services (DRS) are responsible for determining the degree of blindness of an applicant and the determination of medical necessity, respectively.

Three categories of individuals are eligible for services under the VMAP: Mandatory Categorically Needy, Optionally Categorically Needy, and Optionally Medically Needy. In addition, DMAS operates two other indigent healthcare financing programs, the State and Local Hospitalization (SLH) and the Indigent Health Care (IHC) Trust Fund.

1.5 Eligible Providers and Reimbursement

Qualified providers enroll with the VMAP by executing a participation agreement with the DMAS prior to billing for any services provided to Medicaid eligibles. Providers must adhere to the conditions of participation outlined in the individual provider agreement. To be reimbursed for services, providers must be approved by the Commonwealth and be carried on the Provider Master File in the MMIS.

DMAS employs a variety of reimbursement methodologies for payment of provider services. Inpatient hospital and long-term care facilities are reimbursed on a per diem prospective rate, which goes into effect up to 180 days after the beginning of the rate period to allow for retroactive payment adjustments. Settlement is based on a blend of the per diem rate and the APG/DRG Grouper reimbursement methodology. Other providers are reimbursed on a fee-for-service (FFS) basis according to a Geographic Fee File maximum amount allowed. In the FFS methodology, payment is the allowed amount, or the charge, whichever is less; payment is adjusted by co-payment, as well as by any third-party payment. Medicare co-insurance and

deductibles received in the crossover system are reduced to the Medicaid allowance when the Medicare payment and the Medicaid co-insurance amount would exceed the Medicaid-allowed amount. In addition to these payment methodologies, the MEDALLION managed care program uses case management fees as well as FSS. MEDALLION II is fully capitated and uses a per member, per month, payment methodology. Health maintenance organizations (HMOs) participating in the *Options* program are paid a monthly rate based on estimated Medicaid expenditures. Monthly fees are also paid for Client Medical Management (CMM).

2.0 Claims Resolution

The Virginia MMIS Claims Resolution Unit:

- Maintains DMAS-approved pend resolution procedures;
- Resolves pended claims according to DMAS-approved resolution procedures;
- Electronically forwards all pended requests for payment that cannot be resolved by First Health to the appropriate DMAS location.
- Researches and resolves possible duplicate claims;
- Resolves pended claims requiring Title XVIII EOMB research;

Suspended claims from the Claims Processing Subsystem, along with claim images from the (imaging) system, are retrieved on-line for resolution. Resolution staff checks the claims for any keying errors which can be corrected on-line immediately. Claims Examiners research the on-line Edit/Audit Manual and the resolutions instructions included in this manual to determine disposition of pends.

3.0 Resolve Pended Payment Requests

During mainframe processing, validity edits and history audits cause payment requests with errors to be suspended for review by First Health and/or DMAS staff. Pended claims are automatically routed by the system to pend locations at both First Health and DMAS. Locations are listed below. Locations in bold are transfer locations only, meaning that claims are not automatically assigned to them.

Number	Location Name
001	Budget Pend Recycle
002	Financial Pend
100	**First Health Claims Resolution (Easy)**
200	**First Health Claims Resolution (Complex)**
217	Special Batch Pends, Contract Monitor Review
218	Payment Processing Manager
219	Contract Monitor
221	Pricing/DMAS
225	Capitation Payments
230	Medallion Management Fees
250	**First Health Claims Resolution (Supervisor Review)**
300	HUR General Claims Receipt
308	SLH - Hospital
310	SLH – Physician
312	ER – Hospital
313	CMM Claims
314	ER – Physician
317	Non-Resident Aliens
319	TDO – Physician
320	TDO – Hospital
321	DMAS Medical Consultant
333	Out of State Hospitals
400	Medical Support-Professional Consultant Pharmacy Consultant (Dental, PA,0148) 407
600	**Recycle by System**
650	**Pend for Requested Information**

Number	Location Name
700	Pre-authorization
750	**Electronic attachment "park" location**
800	Post Payment Review
900	DMAS TPL

The VAMMIS Pend Resolution Unit is authorized to resolve pended claims in Locations 100, 200, 250 and 650, and has transfer authority for Locations 250 and 750. Locations 250 and 750 are transfer only. Claims are routed to the location with highest priority. For instance, Location 200 requiring complex resolution will receive the pended claim before Location 100 (easy resolution). Claims are retrieved on-line, by claim number, according to oldest pended claim first. Within each pend location, as each pend is resolved and entered back into the claims processing system, the next pended claim is presented. This means that if three people sign-on to location 100, the first person will be presented with the oldest claim in Locaton 100, the next person will be presented with the second oldest claim, and the third person will be presented with the third oldest claim. Whoever finishes a claim first will be presented with the next oldest claim for that location, and so on. The same pended claim cannot be called to more than one workstation at the same time.

As each pended claim is presented, the corresponding claim image stored on the image retrieval system can be retrieved by the operator at the same time providing staff with a paperless image of the original claim for comparison with the on-line claim record. If the claim or a conflicting claim predates the imaging process, the operator will obtain a microfilm copy of the claim or conflicting claim for review. Resolution staff should work all location pends for which they are authorized. After resolution, the claim is re-entered into the system. If more errors are encountered, the system will pend the claim again and route it to the next appropriate location. Each subsequent pend condition is resolved and re-entered until the claim is either paid or denied. The graphic on the following page represents the overall Workflow Process of the Pend Resolution Unit.

Pended claims are reviewed and resolved according to policy and guidelines approved by DMAS. Each edit is first researched in the on-line Edit/Audit Manual, which contains the edit description and instructions for resolution. Resolution is implemented via the appropriate on-line screen.

Pend Resolution staff retrieve electronic claims/claim images individually online for each pended claim presented on the relevant Pend Resolution screen. The [redacted] is the software that produces and archives electronic copies of all VaMMIS imaged documents. Once resolution is determined,

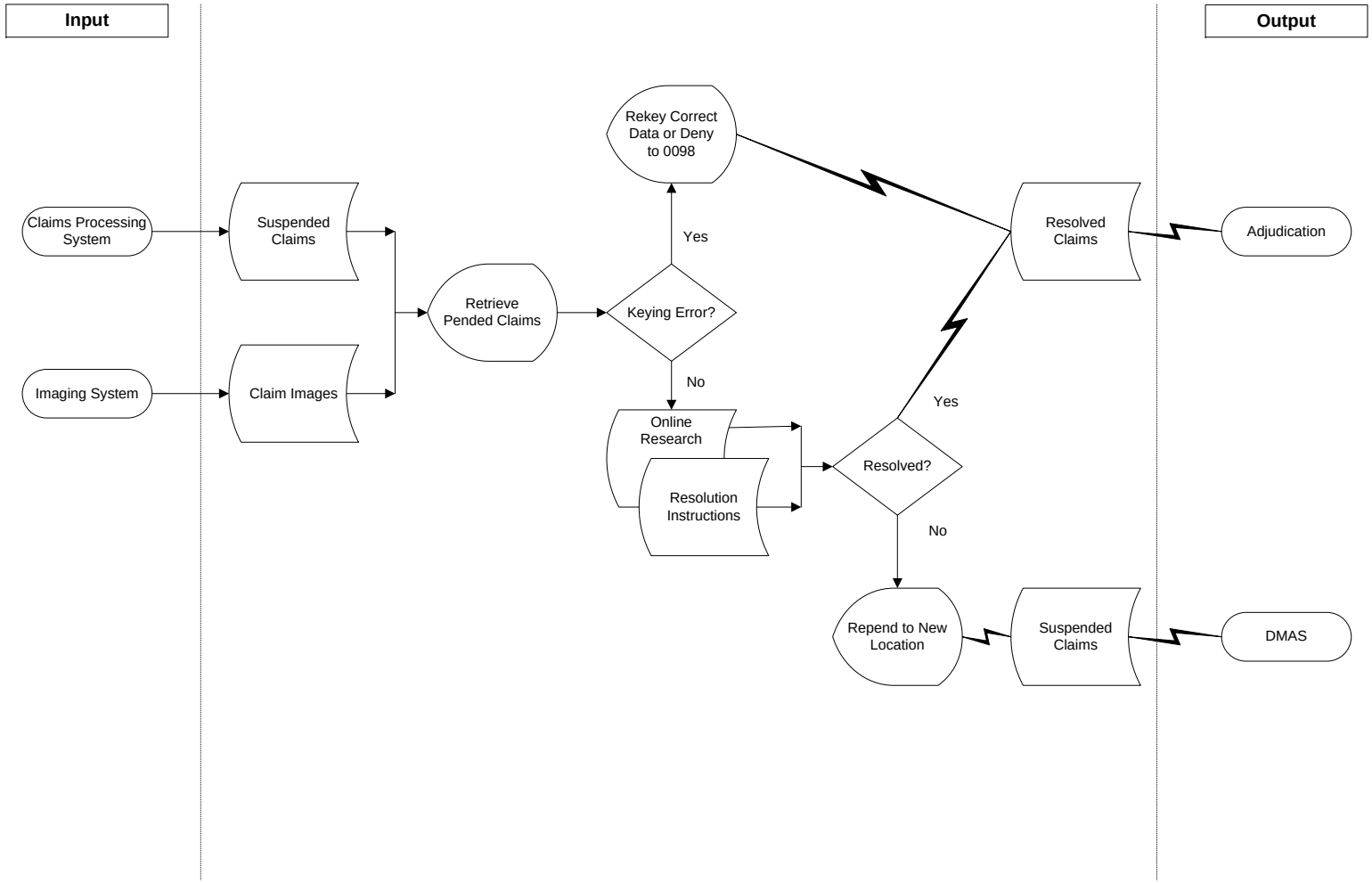
the claim may be corrected, overridden, denied, or repended to the Resolution Supervisor for further review or to DMAS for medical review.

If keying errors are found in the course of resolving a pend, the operator corrects the error if the error is in an unprotected field. If the error cannot be corrected, the payment request is denied using Error Code 0098 and the payment request must be reimaged and rekeyed in data entry.

While pends are presented for resolution in date order, it is possible that a pend may not be resolved timely resulting in aged pends. These pends are listed on aged pend reports (30, 60, 90, or 180 days) which are used by Resolution staff to retrieve and resolve specific claim records. Such claims can be retrieved individually by either Provider ID, claim type, or ICN.

WORKFLOW PROCESS

Resolve Pended Payment Requests



3.1 Access Pended Payment Requests and Images On-Line

The On-line Pend Resolution Master Menu (CP-S-001-02) provides access to the pend resolution screens needed by the VMAP Pend Resolution Unit. The fields on this menu (Location, ICN, Billing Provider ID, Claim Type) allow Resolution staff to either select pended claims for sequential resolution, oldest claim first by location, or specific claims for resolution.

The Location is a required entry. If no other field is entered, and the Enter button is chosen, the oldest pended claim is automatically presented on the screen. Otherwise, staff have the option of entering any other field to call a specific claim number,claim type or billing provider. If a 10 digit number is entered in the Billing Provider ID, only NPI claims will be displayed, otherwise only legacy claims will be displayed. If field is left blank, legacy and NPI will be displayed. If Location is entered, but the user is not authorized to access that location, a screen error message displays.

Once a pended payment request is retrieved using the menu, the payment request is presented on one of several different screen formats according to the type of invoice used to bill the service. These screens are presented in the following subsections of this manual.

Navigation buttons at the botton of the **Pend** screens allow the operator to access various other screens to assist in research. Most screens will have the following navigation buttons:

- **Enter** – Edits the entries and presents system error/information messages
- **Enrollee** - Takes the user to the Enrollee Subsystem
- **Provider** - Takes the user to the Provider Subsystem
- **Procedure** - Takes the user to the Procedure Code Table
- **CHIRP** - Takes the user to the Claims History Information Retrieval Processor
- **Edit Text** - Takes the user to the Error Text Table
- **Remarks** - Takes the user to the screen used to enter comments and remarks about the resolution or disposition of the pended claim
- **Consent** – Takes the user to the screen used to enter consent data
- **PA** – Takes the user to the Prior Authorization menu
- **Conflict Claims** - Takes the user to the Pend Resolution Conflicting Claims (CP-S-001-09) screen
- **Clear Form**- Clears all the data entered in the screen and allows the user to enter new data
- **Diagnosis** - Takes the user to the Diagnosis Code Table
- **Refresh** - Displays the last updated information (if any) from the database

- **Revenue** - Takes the user to the UB Claim Revenue Data (CP-S-001-04) screen (UB screen only)
- **Adjudication** - Submits the claim to the adjudication process.
- **Image** - Displays an image of the pended payment request.
- **Attachment** - Displays an image of the Claim Attachment Form and it's attachments.
- **Value Codes** – Takes the user to the Value Code Table (CP-S-008-13) (UB screen only)

Procedure

1. From the **Virginia Medicaid Main System Menu**, click on the **Invoice Processing** icon to display the **Claims Processing Main Menu** (CP-S-001-01).
2. Choose (click on) the *Pend Resolution Menu* from the selections listed on the **Claims Processing Main Menu**.
3. When the **Online Pend Resolution Menu** (CP-S-001-02) displays, key your authorized pend location in the **Location** field and choose *Enter*. The oldest pended claim for your location displays on the screen
4. Choose the **Image** button to access the corresponding claim image.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line HELP system.

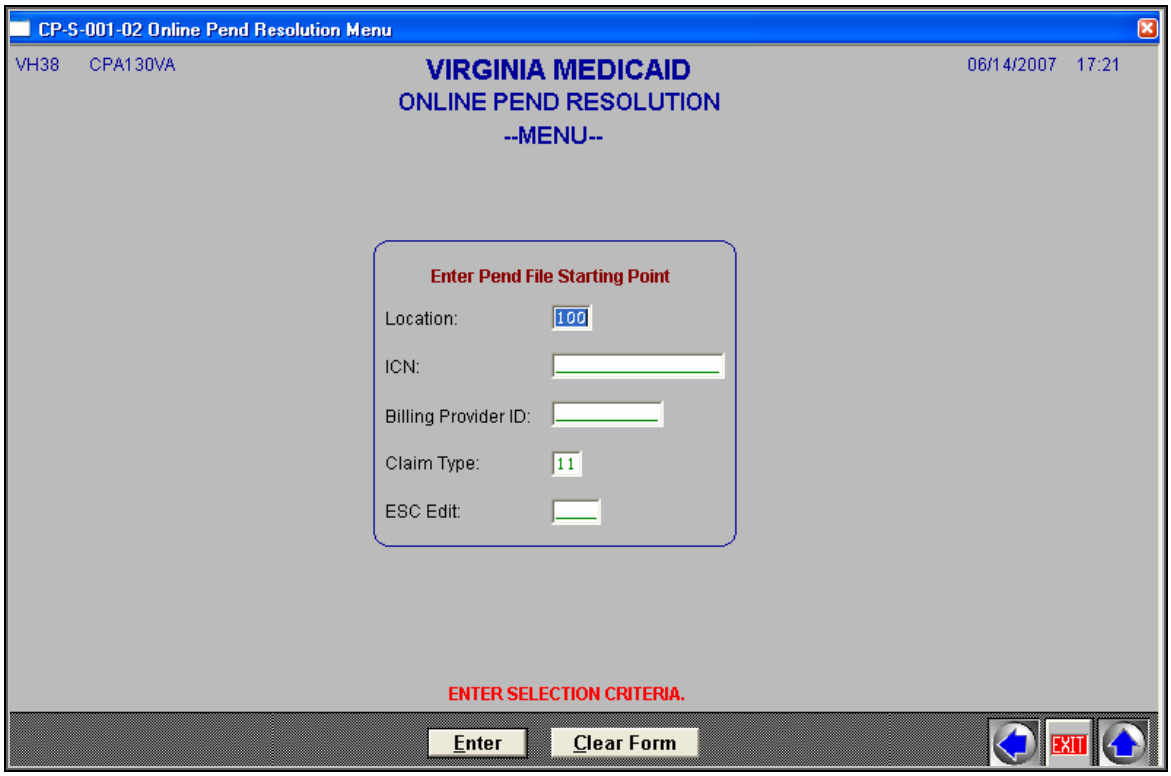


Figure 3.1.1 – Sample Online Pend Resolution Menu CP-S-001-02

3.1.1 UB

The UB Claim Online Pend Resolution screen (CP-S-001-03) displays codes for errors that caused a payment request submitted on a UB invoice to pend. Because the UB document contains a large volume of data, this screen contains only part of the UB data. The remainder of the UB data is maintained on the UB Claim Revenue Data Online Pend Resolution screen (CP-S-001-04) and the Value Code Screen (CP-S-008-13). From this screen, other screens can be accessed for additional data entry or data inquiry by choosing one of the navigation buttons at the bottom of the screen:

Procedure

1. On the **Online Pend Resolution Menu** (CP-S-001-02), enter your location code in the **Location** field.
2. If you are assigned to work a specific UB claim type, enter the claim type code in the **Claim Type** field.
3. Choose *Enter*. The first pended UB claim for the selected claim type displays on the **Online Pend Resolution** screen (CP-S-001-03).

4. Begin working the first error code displayed in the **Errors** field for which you are authorized to resolve.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line Help system.

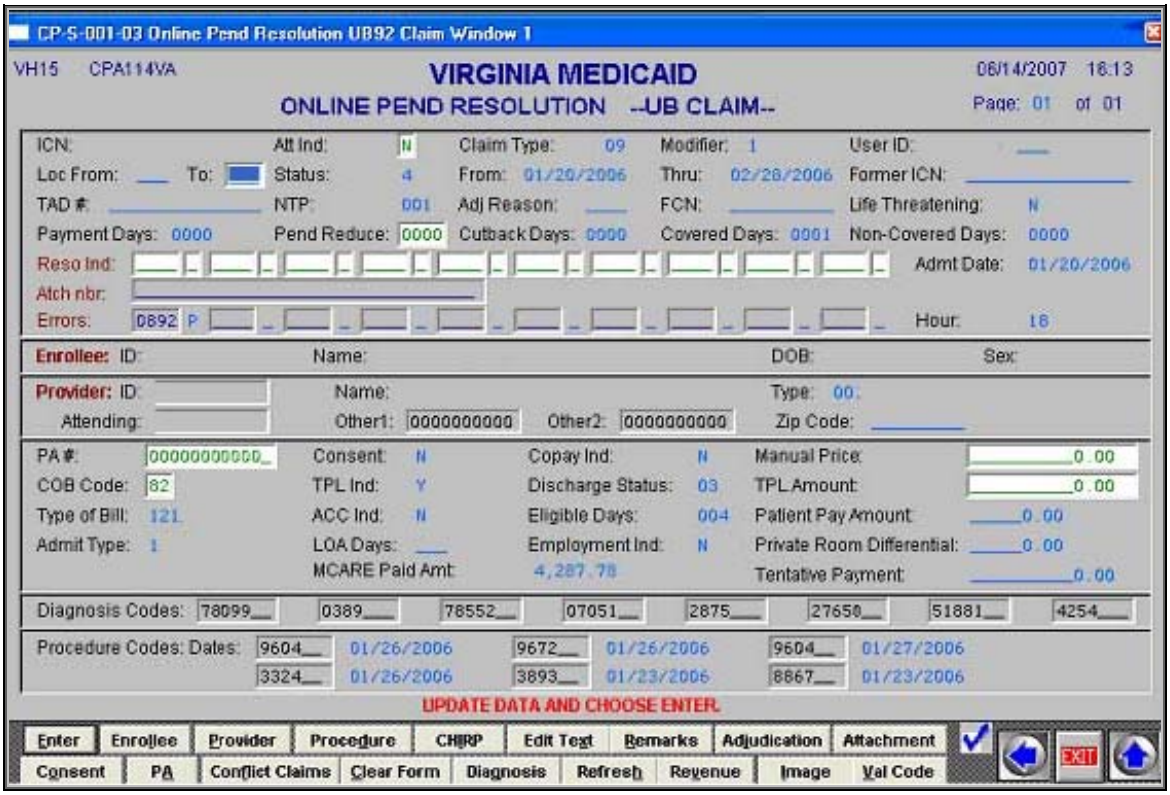


Figure 3.1.1.1 – Sample Online Pend Resolution UB Claim CP-S-001-03

3.1.2 UB Claim Revenue Data

The UB Claim Revenue Data Online Pend Resolution screen (CP-S-001-04) is the screen that displays revenue code/unit data for the pending UB payment request. Once information is reviewed or updated, clicking on the Enter button at the bottom of the screen edits the entered data. Resolution staff can return to the UB Claim Online Pend Resoluton screen (CP-S-001-03) and continue or complete the resolution process.

Procedure

1. If appropriate to the resolution, enter changes in the appropriate field(s) and choose **Enter** to edit the entry (ies).
2. Click on the Left Arrow button to return to the first **UB Claim Online Pend Resolution** screen (CP-S-001-03) and continue or complete the resolution process.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line Help system.

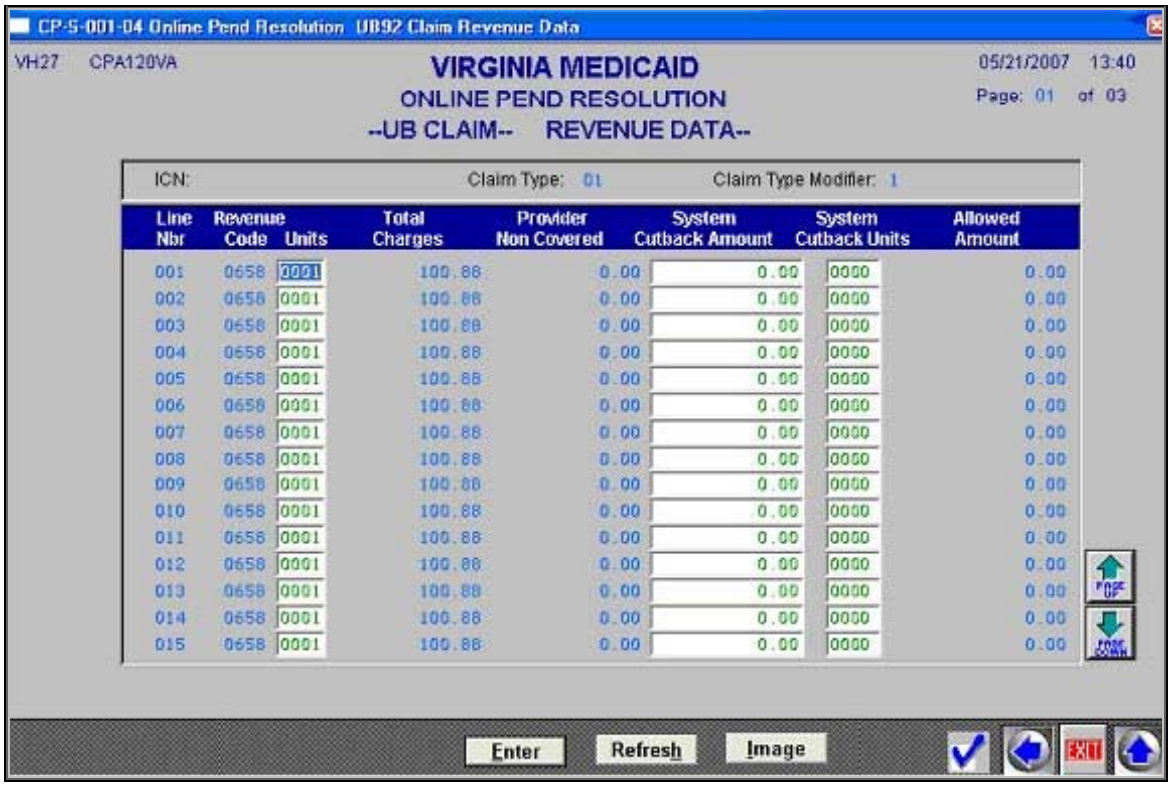


Figure 3.1.2.1 – Sample Online Pend Resolution Screen UB Claim Revenue Data CP-S-001-04

3.1.3 UB Claim Value Codes

The UB Claim Value Code Online Pend Resolution screen (CP-S-008-13) is the screen that displays value code data for the pending UB payment request. Resolution staff can return to the UB Claim Online Pend Resoluton screen (CP-S-001-03) and continue or complete the resolution process.

Procedure

1. Click on the **Left Arrow** button to return to the first **UB Claim Online Pend Resolution** screen (CP-S-001-03) and continue or complete the resolution process.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line Help system.

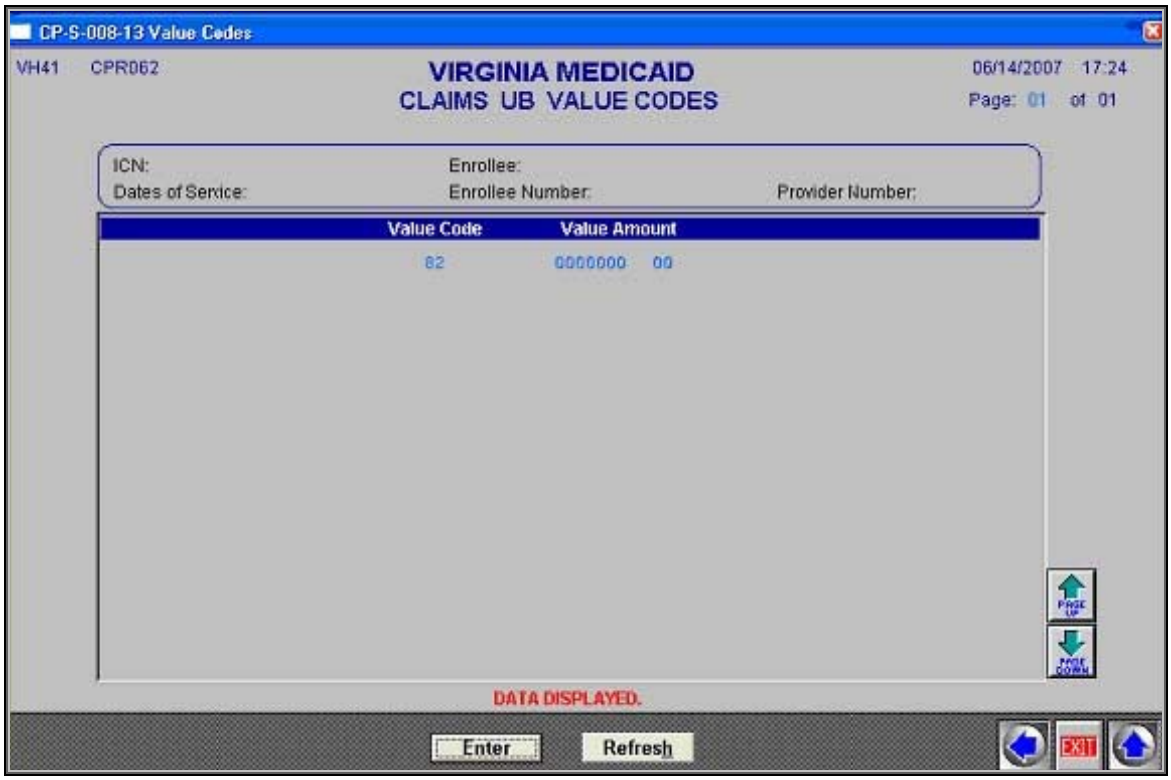


Figure 3.1.3.1 – Sample Online Pend Resolution Screen UB Value Codes CP-S-008-13

3.1.4 1500 Claim

The 1500 Claim Online Pend Resolution screen (CP-S-001-05) is the screen that displays pending payment requests for professional services billed on the 1500 claim. Once information is reviewed or updated, clicking on the Enter button at the bottom of the screen edits the entered data.

Procedure

1. On the **Online Pend Resolution Menu** (CP-S-001-02), enter your location code in the **Location** field.
2. If you are assigned to work a specific professional claim type, enter the claim type code in the **Claim Type** field.
3. Select *Enter*. The first pended 1500 claim for the selected claim type displays on the **Online Pend Resolution** screen (CP-S-001-05).
4. Begin working the first error code displayed in the **Errors** field for which you are authorized to resolve.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line Help system.

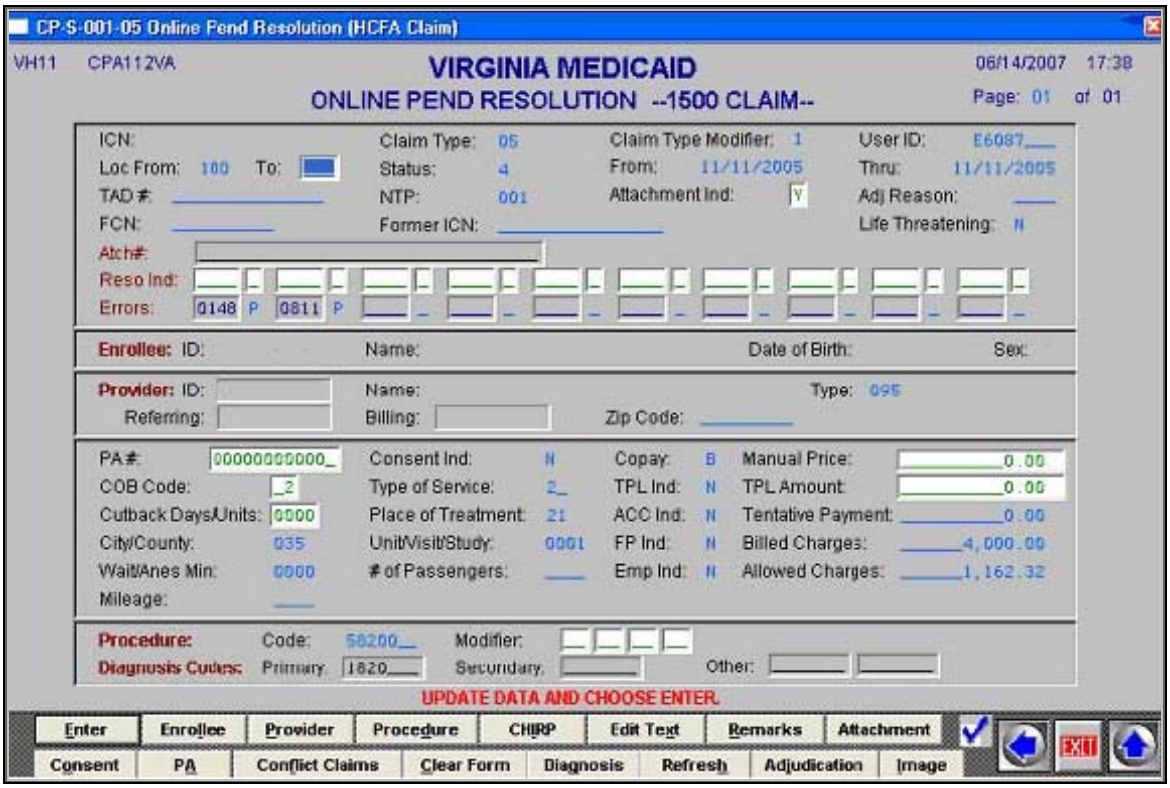


Figure 3.1.4.1 – Sample Online Pend Resolution Screen 1500 Claim CP-S-001-05

3.1.5 Title XVIII Claim

The Title XVIII Online Pend Resolution screen (CP-S-001-06) or (CP-S-00103) is the screen that displays pending payment requests for Medicare Crossover services billed on the Title XVIII invoice. Once information is reviewed or updated, clicking on the Enter button at the bottom of the screen edits the entered data.

Procedure

1. On the **Online Pend Resolution Menu** (CP-S-001-02), enter your location code in the **Location** field.
2. If you are assigned to work crossover claim type, enter the claim type code in the **Claim Type** field.
3. Select *Enter*. The first pended Title XVIII claim displays on the **Online Pend Resolution** screen (CP-S-001-06) or (CP-S-001-03).

4. Begin working the first error code displayed in the **Errors** field for which you are authorized to resolve.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line Help system.

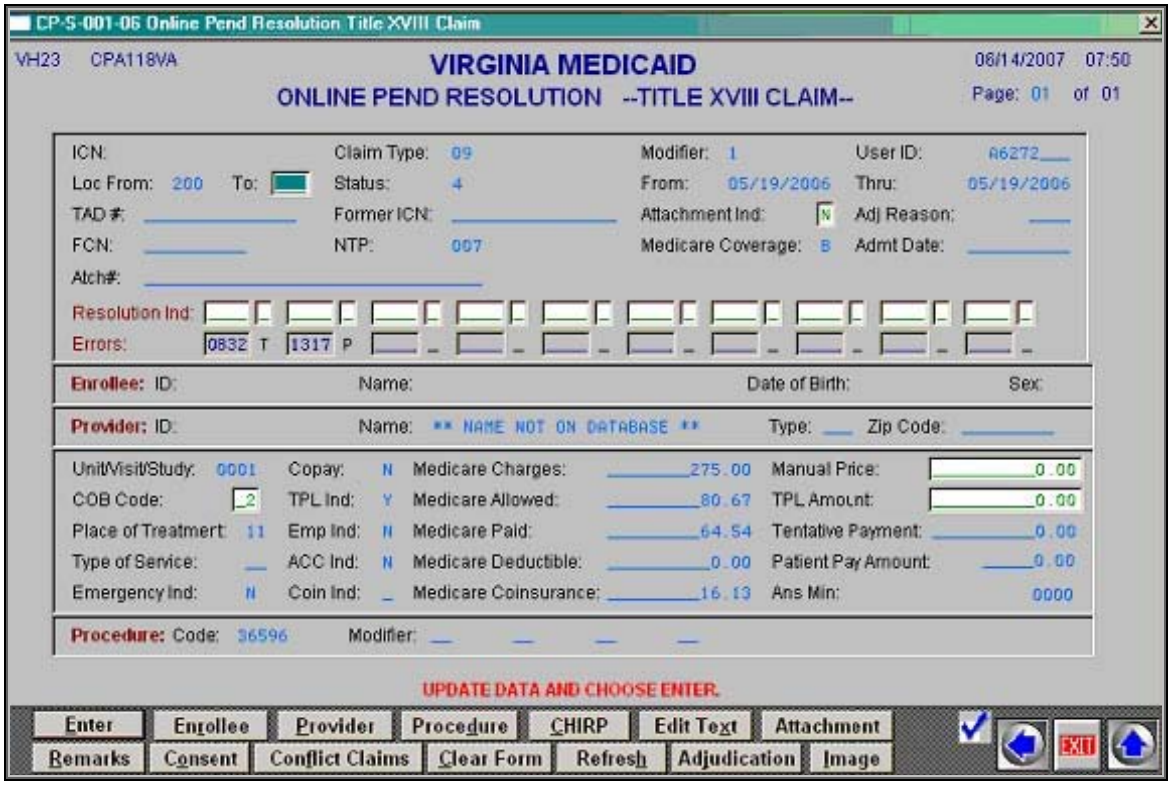


Figure 3.1.5.1 – Sample Online Pend Resolution Screen Title XVIII Claim CP-S-001-06

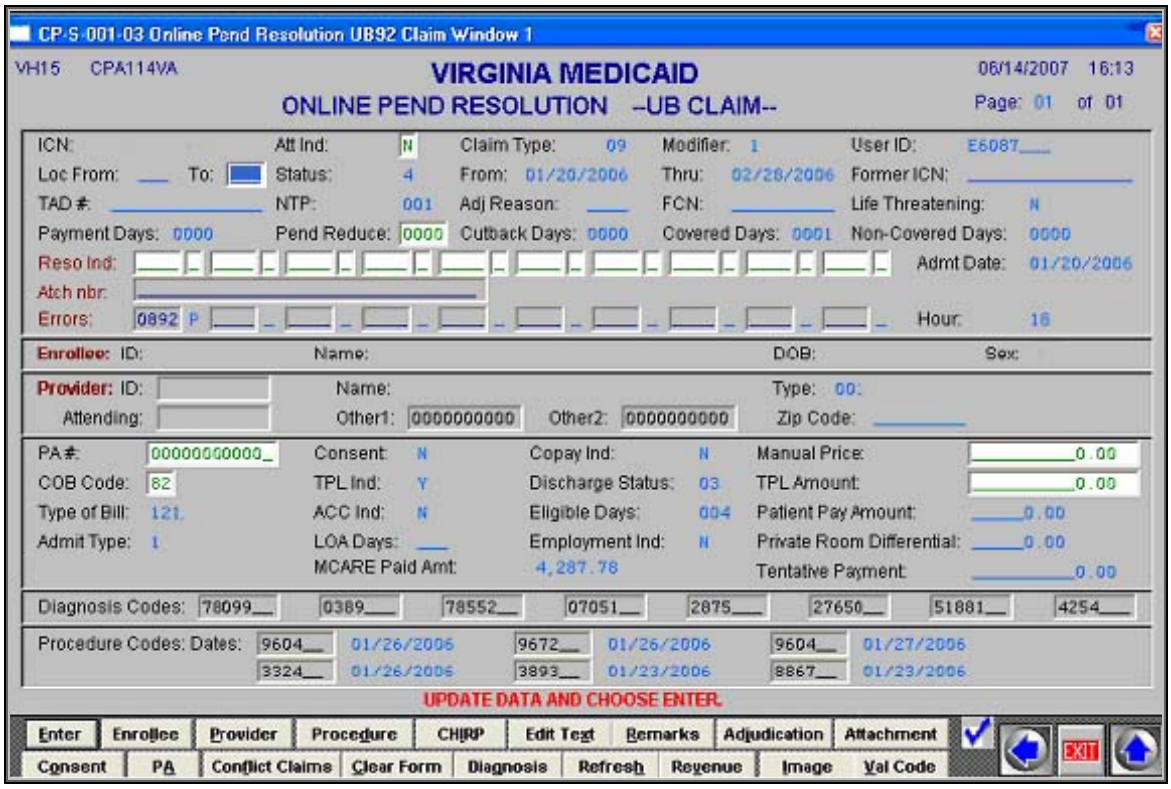


Figure 3.1.5.2 – Sample Online Pend Resolution Screen Title XVIII UB Claim CP-S-001-03

3.1.6 Dental

The Dental Online Pend Resolution screen (CP-S-001-07) is the screen that displays pending payment requests for Dental services billed on the Dental invoice. Once information is reviewed or updated, clicking on the Enter button at the bottom of the screen edits the entered data.

Procedure

1. On the **Online Pend Resolution Menu** (CP-S-001-02), enter your location code in the **Location** field.
2. If you are assigned to work dental claim type, enter the claim type code in the **Claim Type** field.
3. Select *Enter*. The first pended dental claim displays on the **Online Pend Resolution** screen (CP-S-001-07).
4. Begin working the first error code displayed in the **Errors** field for which you are authorized to resolve.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line Help system.

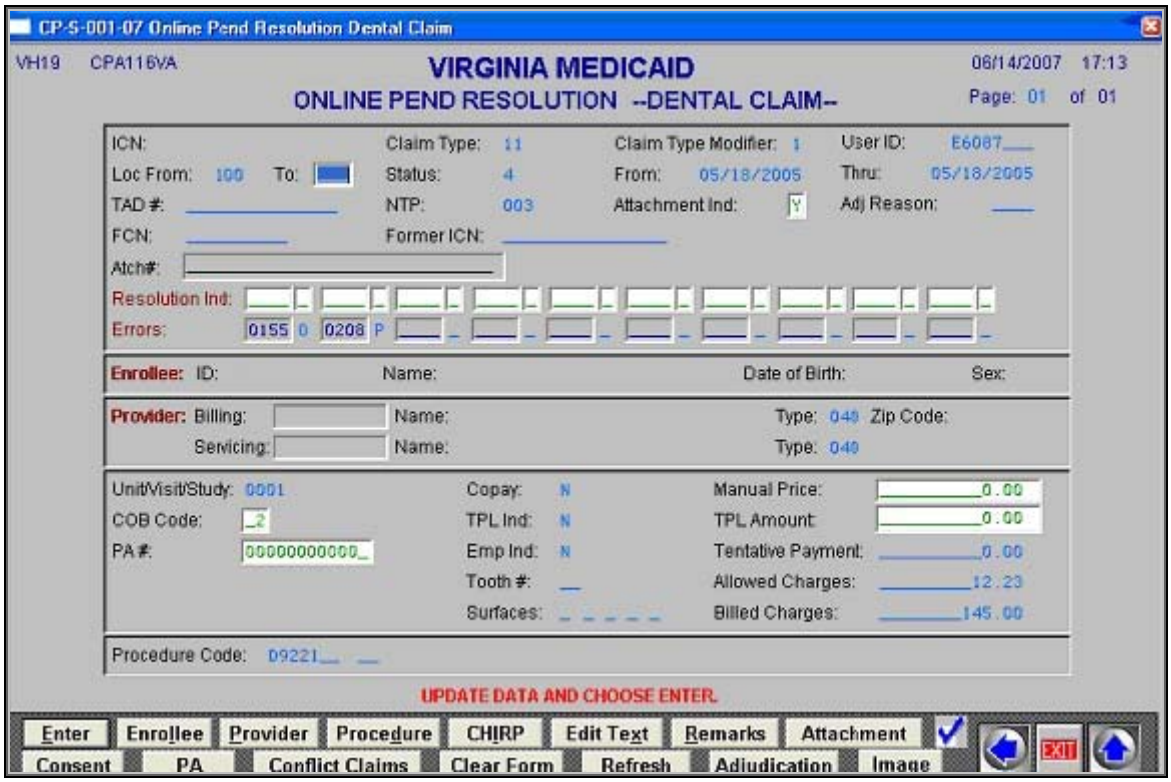


Figure 3.1.6.1 – Sample Online Pend Resolution Screen Dental Claim CP-S-001-07

3.2 Online Pend Procedures

Resolving pended payment requests is an on-line function that does not require the use of paper pend lists, wrappers, or pend sheets. All steps in the resolution process are performed on-line.

Procedure

1. From the **Virginia Medicaid Main System Menu,** click on the **Invoice Processing** icon to display the **Claims Processing Main Menu** (CP-S-001-01).
2. Choose (click on) the *Pend Resolution Menu* from the selections listed on the **Claims Processing Main Menu**.
3. When the **Online Pend Resolution Menu** (CP-S-001-02) displays, key your authorized pend location in the **Location** field and choose *Enter*. The oldest pended claim for your location displays on the screen.
4. Click the **Image** button to acces the corresponding claim image.
5. Begin with the first error code displayed in the **Errors** field that you are authorized to resolve. If a keying error in a protected field caused the error, deny the claim by entering Error Code *0098* in the first 4-character field of the **Reso Ind** field set, then enter *D* in the

1-character field directly beside the code. Refer to Section 6.1.4, Resolve Keying Errors, for further instructions on keying errors.

6. If there are no keying errors, begin the resolution process by researching the error code on-line. Refer to Section 6.1.3, Determine Resolution Using Edit/Audit Manual, for instructions.
7. As you enter corrected data into the appropriate fields, choose **Enter** to edit the data. You may edit each changed field individually, or wait until all fields have been entered and choose **Enter** to edit at one time. Fields in error will be highlighted for re-entry.
8. If the resolution instructions are to deny the payment request, do so by entering the 4-character ECS number (the number displayed in the Errors field) in the **Reso Ind** field and *D* in the **Disposition Indicator** field which is the 1-character field that follows each **Reso Ind** field.
9. If the resolution instructions are to override the edit, do so by entering the 4-character ECS number (the number displayed in the **Errors** field) in the **Reso Ind** field and *O* in the **Disposition Indicator** field which is the 1character field that follows each **Reso Ind** field.
10. If the resolution instructions are to repend the payment request, do so by entering the 3-character new location code in the **Loc To** field that follows the **Loc From** field. If you repend a payment request to another location, you must enter remarks on the **Online Pend Resolution Remarks Entry** screen (CP-S-001-10) to explain why you are sending the pend to the new location. Refer to Section 6.1.7, Enter On-line Pend Resolution Remarks, for instructions.
11. When all fields in error have been corrected, or you have entered a deny, override or new location, choose **Adjudication** to re-enter the claim into the processing system.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line Help system. For resolution instructions for each error code, refer to the Edit/Audit Manual which can be accessed through the On-Line Help system.

3.3 Determine Resolution Using Edit/Audit Manual

The Virginia MMIS Online Documentation Library contains the Edit/Audit Manual. The library is accessible through the Help component available on the toolbar at the top of the screen page. The Edit/Audit Manual contains a description of each edit (in ascending numeric order), identifies the cause of the error condition and the data field affected, and provides instructions for correcting the error or for otherwise resolving the pend. Instructions are provided only for errors that are set to pend to First Health pend locations.

Procedure

1. Click on *On-Line Help* in the toolbar at the top of your screen. Choose *On-line Help* from the dropdown menu to retrieve the **Virginia MMIS Online Documentation Library**.
2. Click on *Edit/Audit Manual* to display a list of error codes in ascending numeric order.
3. Each error has been assigned an Edit number and an ESC number. The Edit number is the code that was in the old system. The ESC number is the Edit Sequential Code. Most edits have the same number for both the Edit number and the ESC number. Many of the combination edits and duplicate edits have multiple ESC numbers assigned to each Edit number to separate specific criteria. The Edit/Audit manual list presents the ESC number first and the Edit number second. The ESC number is the one that will appear on the **Pend** screen and the number you need to access when you look up a resolution. The Edit number is the one that will print on the RA.
4. Use the keyboard down arrow key to scroll down and find the ESC number you are looking for, then click on the desired code to highlight the selection. Click on the Display button.

   OR

   Enter the ESC number from the **Pend** screen in the **ESC Number** field on the **HELP** screen and click on *Display*.
5. The requested edit/audit information displays. If the edit pends to a First Health location, the resolution instructions can be accessed by clicking *View Resolution as PDF* at the end of the display.
6. In cases of multiple ESC numbers for a single Edit number, the detailed resolution instructions will be shown only on the first ESC number for the Edit number. All other ESC entries will have a comment directing you to the ESC that lists the instructions. Use the **Back** button on the menu bar to return to the previous screen and enter the ESC number to which you were referred to find the resolution instructions. If you wish to print the edit information, click on the **Print** button at the top of the edit page.
7. Resolve the edit according to the instructions in the **Resolution** field.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual

3.4 Resolve Keying Errors

DMAS restrictions prohibit entry of certain fields on the pend resolution screens. Such fields are protected, meaning that when entry is attempted, a message displays and the entry is not

allowed. Some fields are absent altogether from the pend resolution screens. If a keying error is detected in a protected field, Resolution staff deny the claim and re-process it through the claims processing system.

Procedure

1. Review the payment request image and compare the data to the data on the **Pend** screen. Pay particular attention to the fields that are part of the edit criteria. For instance, if the error is a possible duplicate, look for keying errors in the **Recipient, Provider, Procedure** and **Date of Service** fields.
2. If a keying error is noted and the field containing the incorrect data is unprotected, that is updateable, key the correct data as shown on the image over the incorrect data in the field on the **Pend** screen. Release the pend to adjudication.
3. If a keying error is noted and the field containing the incorrect data is protected, that is not updateable, deny the pend with ESC number *0098* and enter a *D* in the **Disposition Indicator** field.
4. Print the payment request image and place in a holding area to be picked up and routed to Data Prep for reimaging.

3.5 Transfer to Supervisor

If you are working a pend and encounter a problem you are not able to resolve, you can send the pend to your supervisor for assistance. This should only be done as a last resort after you have tried all means available to resolve the pend.

If you do repend to your supervisor, you must enter remarks that explain exactly why you have sent the claim to the supervisor. Your supervisor will monitor this function closely.

Procedures

1. If you determine you need to refer the pend to your supervisor, enter the location code *250* in the **Location To** field that follows the **Location From** field.
2. Click on the **Remarks** navigation button at the bottom of the screen. The **Remarks** screen will display.
3. Enter remarks stating specifically why you are referring the pend to the supervisor.
4. Refer to Section 6.1.7, Enter On-line Pend Resolution Remarks, for further instructions on entering remarks.

Supervisor

1. Access pend Location 250 daily to review and resolve claims pended to this location.
2. Enter remarks as needed to explain resolution.

3.6 Transfer to DMAS

Resolution instructions for same edits will indicate that the pend should be routed to DMAS. The instructions should indicate the specific DMAS location code.

Whenever you route a pend to DMAS, you must enter remarks that explain exactly why you have referred the pend.

Procedure

1. If you are instructed to refer the pend to a DMAS location, enter the appropriate location code in the **Location To** field that follows the **Location From** field.
2. Click on the **Remarks** navigation button at the bottom of the screen. The **Remarks** screen will display.
3. Enter remarks stating specifically why you are referring the pend to DMAS.
4. Refer to Section 6.1.7, Enter On-line Pend Resolution Remarks, for further instructions on entering remarks.

3.7 Enter Online Pend Resolution Remarks

The Online Pend Resolution Remarks Entry screen (CP-S-001-10) is used to annotate error resolution during the resolution process. This screen can be accessed from any of the Online Pend Resolution screens as necessary to document the action taken. Remarks must be entered whenever a pended payment request is transferred to another location.

Procedure

1. Click on the **Remarks** navigation button at the bottom of the **Pend** screen. The **Online Pend Resolution Remarks Entry** screen (CP-S-00110) will display.
2. The system will populate fields identifying the ICN of the pended claim, the Transfer From and Transfer To locations and the transfer date.
3. Enter freeform text in the **Remarks** field indicating the specific reason you are transferring the pend. Be brief and specific. For example: Review Op report, IC requested.
4. Click *Update* to post the remarks.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line Help system. For resolution instructions for each error code, refer to the Edit/Audit Manual which can be accessed through the On-Line Help system.

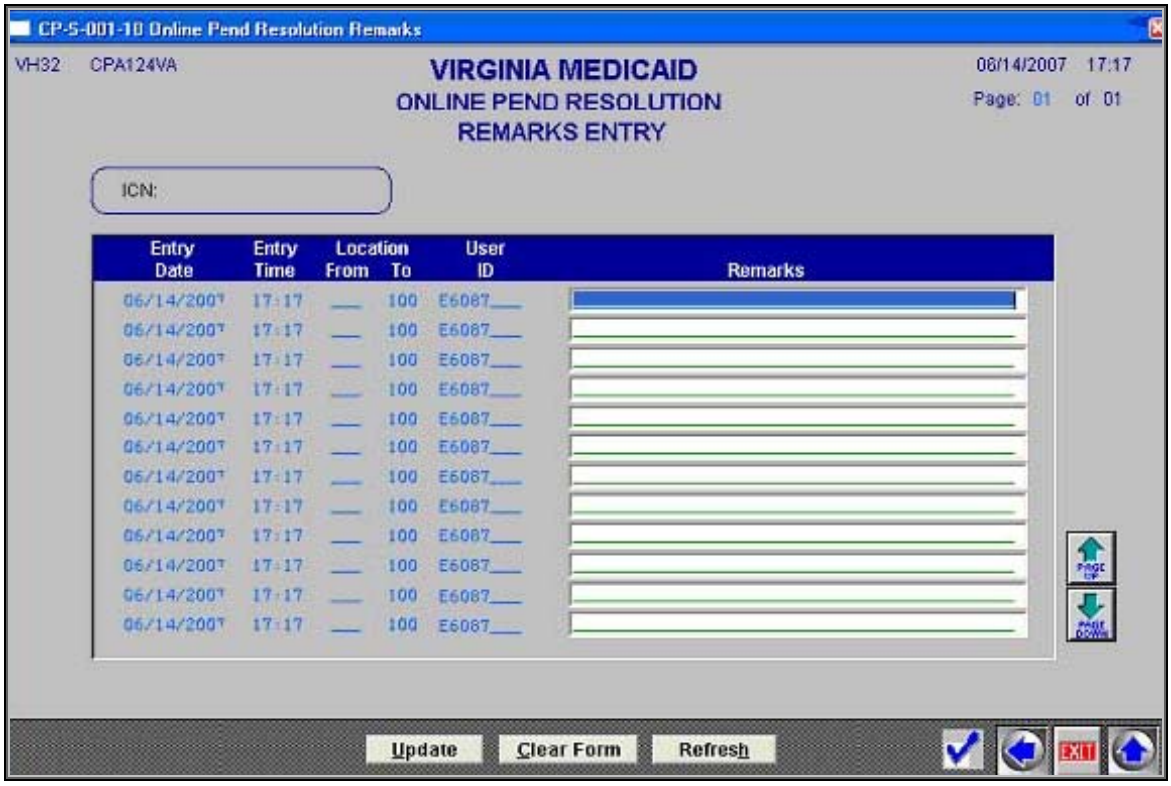


Figure 3.7.1 – Sample Online Pend Resolution Screen Remarks Entry CP-S-001-10

3.8 Enter Consent Forms

Consent forms must be submitted with payment requests for abortion, hysterectomy and sterilization procedures. The system applies the following rules:

1. With the implementation of HIPAA, providers are allowed to submit payment requests electronically for the above-cited procedures and submit the required attachment separately on paper. The electronic claim and the paper attachment will both include an Attachment Control Number (shown on the **Pend** screen as Atch#) that allows retrieval of the attachment image.when working the pended claim.
2. Claims for these procedures will be checked against the Consent File to verify that a consent form has been posted for the procedure and dates of service.
    - ❖ If a consent is found on file and all information matches the claim, the claim will pay.

- ❖ If a consent is not on file and there is no attachment and no ACN, the claim will deny.
- ❖ If a consent is not on file and there is an attachment, the claim will pend. Pend codes are:
  - 278 Review of Sterilization Consent Form
  - 810 Review of Abortion Consent Form
  - 811 Review of Hysterectomy Consent Form

3. If a claim pends and the consent form is attached, Resolution will enter information from the form onto the **Online Pend Resolution Consent Entry** screen (CP-S-011).

A copy of each of the consent forms is included in Appendix D.

Procedure

1. If a claim pends for consent form required, access the attachment image:
   - ❖ For a paper claim, page down on the image retrieval screen to the attachment that follows the claim image.
   - ❖ For an electronic claim, look for the Atch# on the **Pend** screen. Enter the Attach# on the image retrieval screen to access the attachment image. See Section 6.1.13 for further instructions on retrieving attachments for electronic claims.
2. Review the consent form and the service and verify that the consent form meets all requirements.
   - ❖ If the form has errors (patient did not sign form, dates are outside time requirements), deny the claim using the appropriate ESC code for the edit (see edit instructions). In addition to the ESC code, enter the appropriate EOB that explains the specific reason the consent form is not valid. The list of EOB codes and messages is on the following page.
   - ❖ If the form has no errors, click on the **Consent** navigation button on the **Pend** screen and enter the consent form information on the screen.
   - ❖ Return to the pend and click the **Adjudication** button to release the claim to adjudicate. Claim should pay based on consent form information unless other errors set.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line Help system. For resolution instructions for each error code, refer to the Edit/Audit Manual, which can be accessed through the On-Line Help system.

Consent Form EOBs – Enter EOB in addition to the ESC denial code.	
EOB #	**Message That Prints on RA**
610	Consent Form Must be Signed and Dated by Enrollee Prior to Surgery
611	Statement of Person Obtaining Consent Not Completed
612	Signature Date on DMAS 3004 is Not at Least 30 Days From Date of Sterilization
613	Physician's Statement on DMAS 3004 Not Filled in Completely
625	Abortion Certification Not Acceptable
661	Please Complete All Portions of DMAS 3004 and Resubmit
695	Consent Form Must be Signed by Provider
696	Interpreter's Statement Not Filled in Completely
697	Physician Statement Not Completed by Performing Physician
1000	Consent Form Signed and Dated by Physician Prior to Procedure
1001	Invalid Consent Form.
1002	Entire Consent Form Must be Legible
1003	Non-Therapeutic Abortion Not Covered by Medicaid
1004	Enrollee Statement on Consent Form Not Filled in Completely
1005	Dates of Enrollee and Consent Form Signatures Must Be the Same
1006	Surgery Date on Payment Request Not Same as Consent Form

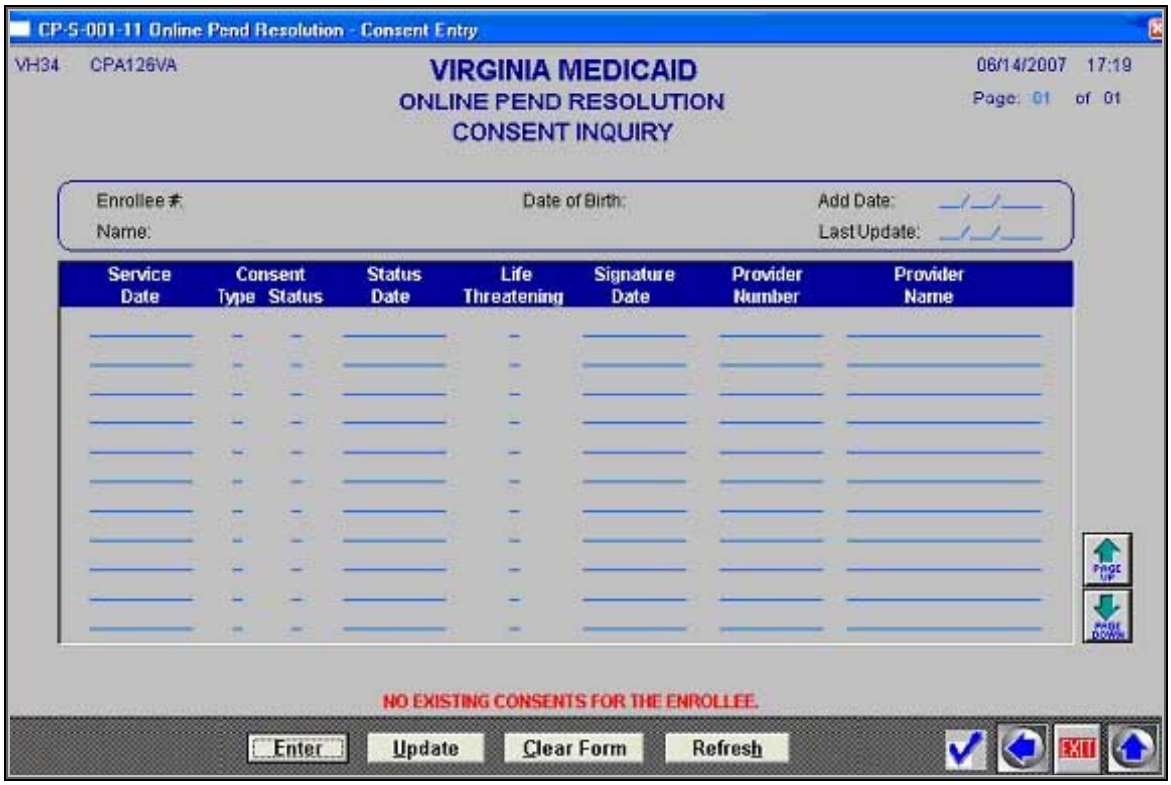


Figure 3.8.1 – Sample Online Pend Resolution Consent entry Screen CP-S-011

3.9 Work Location 650 Pends

Some edits automatically generate a letter to the provider requesting additional information, such as ER report or a DMAS form. These edits will park the pend for 21 days in Pend Location 650 awaiting receipt of the requested information. The provider is instructed to return the information with a copy of the letter in order to match the information to the original pending claim using the ICN that is printed on the letter. When the letter and requested information are received in Data Prep, the documents are to be worked daily because the pending claim will be automatically denied if not worked within the number of recycle days set for the edit.

Procedure

1. Receive the letter with attached documentation from Data Prep. Date stamp the letter with the date of receipt.
2. Access the pended claim by entering the ICN of the pended claim in the **ICN** field. Choose **Enter** to display the pend. You must have security authorization for Location 650 in order to access these claims.
3. Check the edit resolution description to find the pend location that is responsible for reviewing the documentation.

4. Enter the appropriate DMAS location code in the **Loc To** field on the **Resolution** screen.
5. Enter a comment on the **Comment** screen indicating that the documentation has been received and is being forwarded to DMAS.
6. Package the document(s) and attached letter that was submitted in response to the request and route to the appropriate DMAS unit.
7. If the resolution instructions indicate that Pend Location 100 or 200 is responsible for reviewing the documentaion, follow the instructions given for the edit and resolve the pend without changing the location.

Note: When an ER claim with the letter (CP-O-444-06) is no longer pending, the letter and attached documentation is sent to DMAS.

MMIS Error Messages:

The messages **Claim Pended To Auto Recycle Location 600** or **ICN Currently Not In Pend Status** are displayed when a claim has been flagged for auto adjudication or already paid. If either message is displayed, the documentation should be placed in the recycle bin.

3.10 Retrieve Microfilm Images

In instances where the document image is not available on-line, the image can be retrieved from microfilm. Based on Julian date, the microfilm cartridge is pulled, and the claim is copied. A Claim Review Form is completed for each claim pulled, and attached to the copy of the corresponding claim.

Procedure

1. Complete the top portion of a **Claim Review Form** for each claim to be pulled.
2. Identify Julian date of the microfilm needed. Pull the microfilm cartridge containing the microfilm image of the claim document.
    - ❖ If any microfilm cartridge is not present, notify the Resolution Lead.
    - ❖ If the film has been checked out, go to the identified staff to see when it can be borrowed.
    - ❖ If the film has not been checked out, or the person who checked it out does not have it, note that the film is missing in the **Discrepancy Report** section of the **Claim Review Form**.
3. Make a copy of each pulled claim along with any attachments to the claim using the reader printers.

- ❖ If any claim cannot be found on the film, note that the claim is missing on a **Discrepancy Report** section of the **Claim Review Form.**

4. Attach each claim and its attachments to the corresponding **Claim Review Form**.
5. Return all microfilm to the library, placing it in the appropriate storage area.

3.11 Work Aged Pends

Pended claims stay in the system until they are resolved. Claims that have remained pended for more than 30, 60, 90, or 180 days are listed on aged reports which are monitored by the Pend Resolution Supervisor(s) who determine priority and processing, and direct and monitor resolution. Although aged claims are presented by location, oldest claim first, in the daily retrieval of pended claims, such claims can be accessed specifically by either Provider ID, claim type, or ICN. This means that whenever an aged pended claim is retrieved by a specific calling criteria, the same claim cannot be called to more than one workstation at a time. Therefore, the pended claim will not be presented to any other Resolution staff working regular oldest-claim-first by location if the claim is currently being worked at a workstation.

Reports used to identify aged pends are:

- CP-O-053-01 Weekly Aged Pend List - ICN sequence
- CP-O-053-02 Weekly Aged Pend List - Provider, ICN, sequence
- CP-O-406 Pended Claims Over 30 Days Old
- CP-O-409-01 Aged Pended Claims with Status of 4
- CP-O-409-02 Aged Pended Claims with Status of 7.

Samples of these reports are included in Appendix A.

Procedures

1. Supervisor:
    - ❖ Review the aged pend reports on a weekly basis to identify those pends that are over 30 days old that are in pend locations controlled by First Health, including Location 250, pend to supervisor.
    - ❖ Assign groups of pends from the reports to be worked on a priority basis. Pends can be assigned by oldest date, claim type, error code, provider number, or other sort that is deemed most efficient to eliminate the pends.
2. Resolution Clerk:

- ❖ Work the pend listing that has been assigned by entering the location code and the ICN of the first pended claim on the listing. Refer to the Edit/Audit Manual through On-Line HELP for resolution instructions.
- ❖ If you are not able to resolve the aged pend with information available, seek assistance from your supervisor the Contract Monitor for claims processing.

3. Supervisor:
    - ❖ Spot-check the aged pend listings to verify that aged pend errors have been processed according to resolution instructions.

3.12 Retrieve Attachments for Electronic Pends

With the implementation of HIPAA, providers are allowed to submit payment requests electronically and submit the required attachment separately on paper. The electronic claim and the paper attachment will both include an Attachment Control Number (shown on the **Pend** screen as Atch#) that allows retrieval of the attachment image.when working the pended claim

Procedure

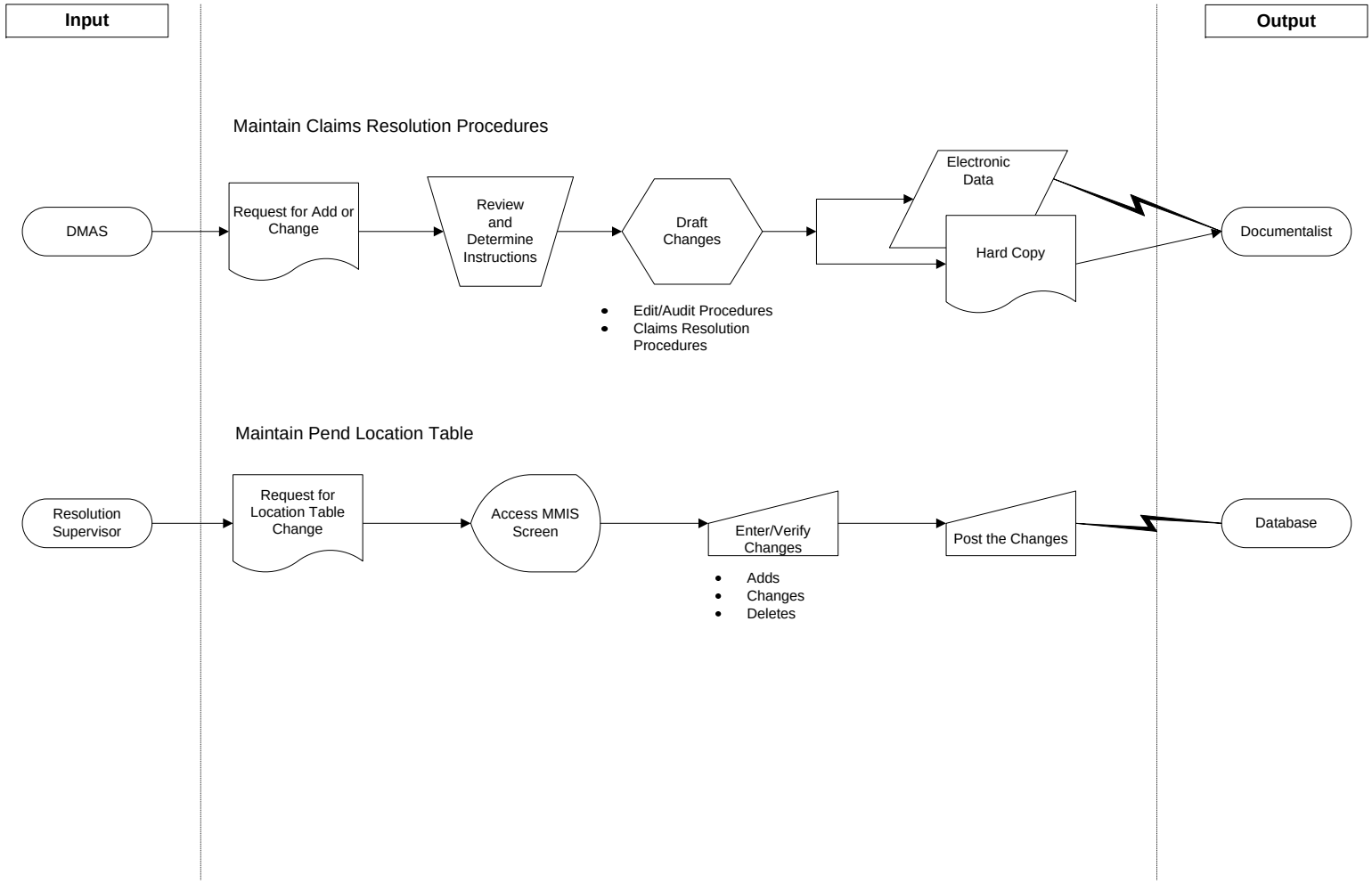
1. If an electronic claim pends for an edit that requires an attachment, or where the resolution instructions indicate attachment information should be reviewed, look for an Attachment number on the **Pend** screen.
2. If a number is found, choose the **Attachment** button to access the attachment image.
3. If the image is not found, transfer the claim to Location 750. This will “park” the claim for three days awaiting arrival of the attachment. Continue to transfer to Location 750 until the attachment image is found, or until 21 days.
4. If the attachment is still not on the image file after 21 days, the system will display a message on the **Pend** screen indicating that 21 days has elapsed and that transfer to 750 will result in denial of the claim. Unless otherwise instructed by your supervisor, transfer the claim to Location 750 and allow the claim to automatically deny.

4.0 Maintain Pend Resolution Procedures

The Edit/Audit Manual contains pend resolution procedures for each error code. This manual includes a descriptive name, brief explanation of what caused the claim to pend, identification of the affected field, and instructions for resolving the error condition. The systems unit is responsible for maintaining the edit criteria. Claims Resolution is responsible for maintaining the resolution procedures with DMAS input and approval. The manual is maintained using Docutraxx and is accessible through the the On-line Help component of the VaMMIS.

WORKFLOW PROCESS

Maintain Pend Resolution Procedures



4.1 Determine Resolution Procedures

Error resolution procedures must be approved by DMAS prior to any implementation of a process. Changes may be initiated either by DMAS or by VMAP operations. DMAS submits requests for change to the VMAP Operations Manager, who then discusses the process to be developed and the impact on operations with the Resolution Supervisor. The Operations Manager works with the Resolution Supervisor to evaluate any new or existing procedures for efficiency and productivity. These procedures are submitted to DMAS for approval. DMAS works with the Operations Manager and the Resolution Supervisor to define and clarify the intent and execution of the change. DMAS notifies the Operations Manager, in writing, of the approval of the change, which is then incorporated into the Edit/Audit Manual.

Procedure

1. Receive request from DMAS to add, change or delete resolution procedures for a specific edit. This may take the form of e-mail, memo or DMAS letter.
2. Operations Manager and Resolution Supervisor review the instructions and determine how the instructions impact the procedures established for the edit in question.
3. If clarification is needed, the Resolutions Manager discusses the instruction with the DMAS reviewer.
4. Resolutions Manager drafts a procedure that addresses the DMAS instructions and submits the draft to DMAS for approval. This may be done through e-mail or submitted to the DMAS reviewer in person.
5. DMAS approves the procedure.

4.2 Document Resolution Procedures

When DMAS approves changes/additions to pend resolution procedures, the VMAP Supervisor incorporates them into the Edit/Audit Manual. If the change also impacts the procedures in the Claims Resolution Procedures Manual, the Resolution Supervisor also initiates these changes. The Resolution Supervisor drafts the changes in a Word document and submits the Word document to the Documentatlist to be incorporated into the Edit Audit Manual and/or the Claims Resolution Operations Procedures Manual.

Procedure

1. Receive approval from DMAS for the edit resolution change.
2. Determine whether a change is also needed to the Claims Resolution Operations Procedures Manual. If so, write the change in a Word document.

3. Submit soft and hard copies of the changes, with instructions, to the VMAP documentalist who will update the edit instructions in Docutraxx and any general procedure changes to the Claims Resolution Operations Procedures Manual.
4. After changes have been entered, review the results to verify accuracy. If corrections are needed, submit corrections to the Documentalist.
5. Once the changes are documented, notify staff of the changes and conduct training, if needed.

4.3 Maintain Pend Location Table

The Claims Resolutions screens are accessed by location code. Each operator is assigned to one or more location codes and can only work pends for the location(s) to which they are assigned. The Claims Processing Subsystem provides a screen that allows adds and changes to the table that maintains user pend locations. The Resolution Supervisor has security to access and update this table through the on-line User Pend Location Screen (CP-S-001-00).

Procedure

1. On the **Main System Menu**, click on the **Invoice Processing** icon. The **Claims Processing Main Menu** will display.
2. Click on *User Pend Locations*. Choose *Enter*. The **User Pend Location Screen** will display.
3. Click on the Function Change, (to add, change or delete) or *Inquiry*.
4. Enter the User ID (alpha character and four numerics) of the person whose access you want to add, change or delete. Choose *Enter*.
5. If the User ID you entered is not on file, a message will display, **No Records Found**. You may then enter the record.
    - ❖ Enter *A* in the **Select** field
    - ❖ Enter the User ID in the **User ID** field.
    - ❖ Enter the three digit Location Code (100, 200, 250) in the **Location** field.
    - ❖ If the user is to be limited to a specific provider's claims, enter the Provider ID in the **Provider** field. If no restriction, enter all zeros. Choose **Enter** to edit the entry.
    - ❖ When the entry is free of errors, choose *Update* to post the record.
    - ❖ You may then enter another location for the same user or go on to the next user. The **Clear Form** button will clear the screen to allow a new start.

6. To change or delete an existing user record, Step 4 will result in display of a list of all locations assigned to the user.

   - ❖ To add a new location, follow the same steps used in Step 5.
   - ❖ To delete a location, enter a *D* in the **Select** field beside the record to be deleted. Choose *Update* to delete the record.
   - ❖ To Change a record, enter a *C* in the **Select** field beside the record to be changed. Enter the change in the appropriate field. Choose **Enter** to edit the entry. Choose *Update* to post the record.

For more details on specific screen navigation and field entries or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line Help system. A sample screen is displayed on the following page.

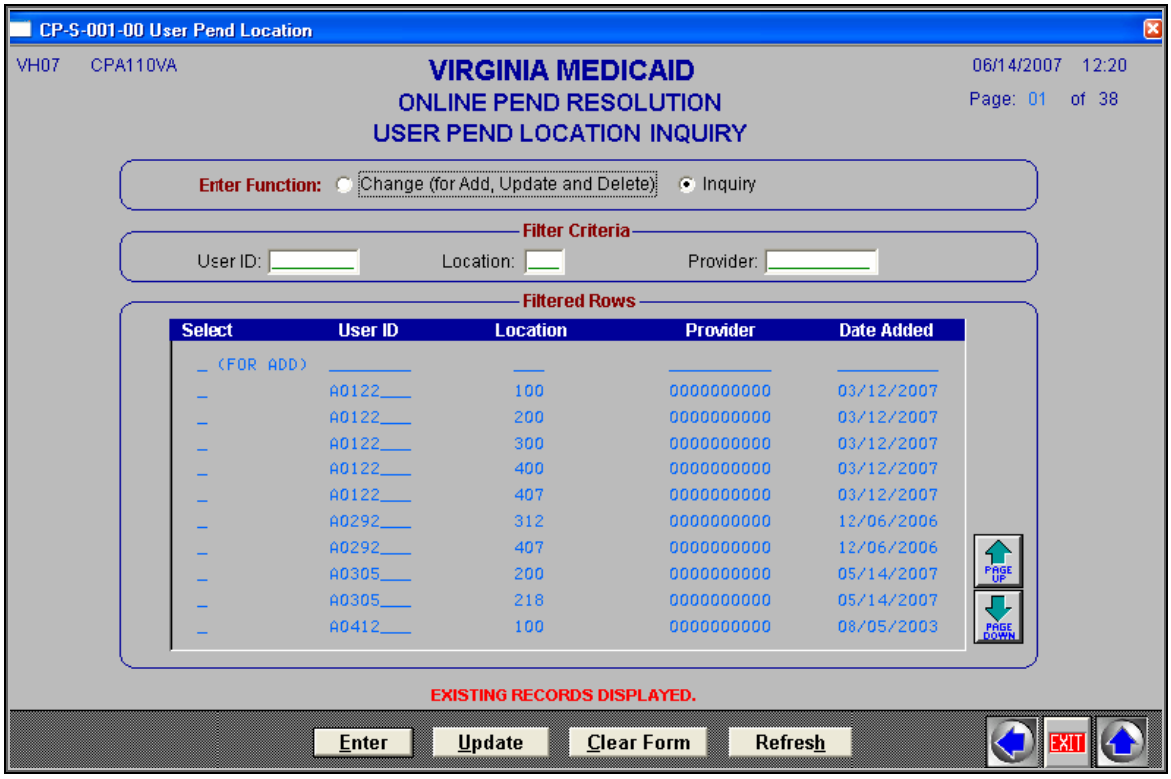


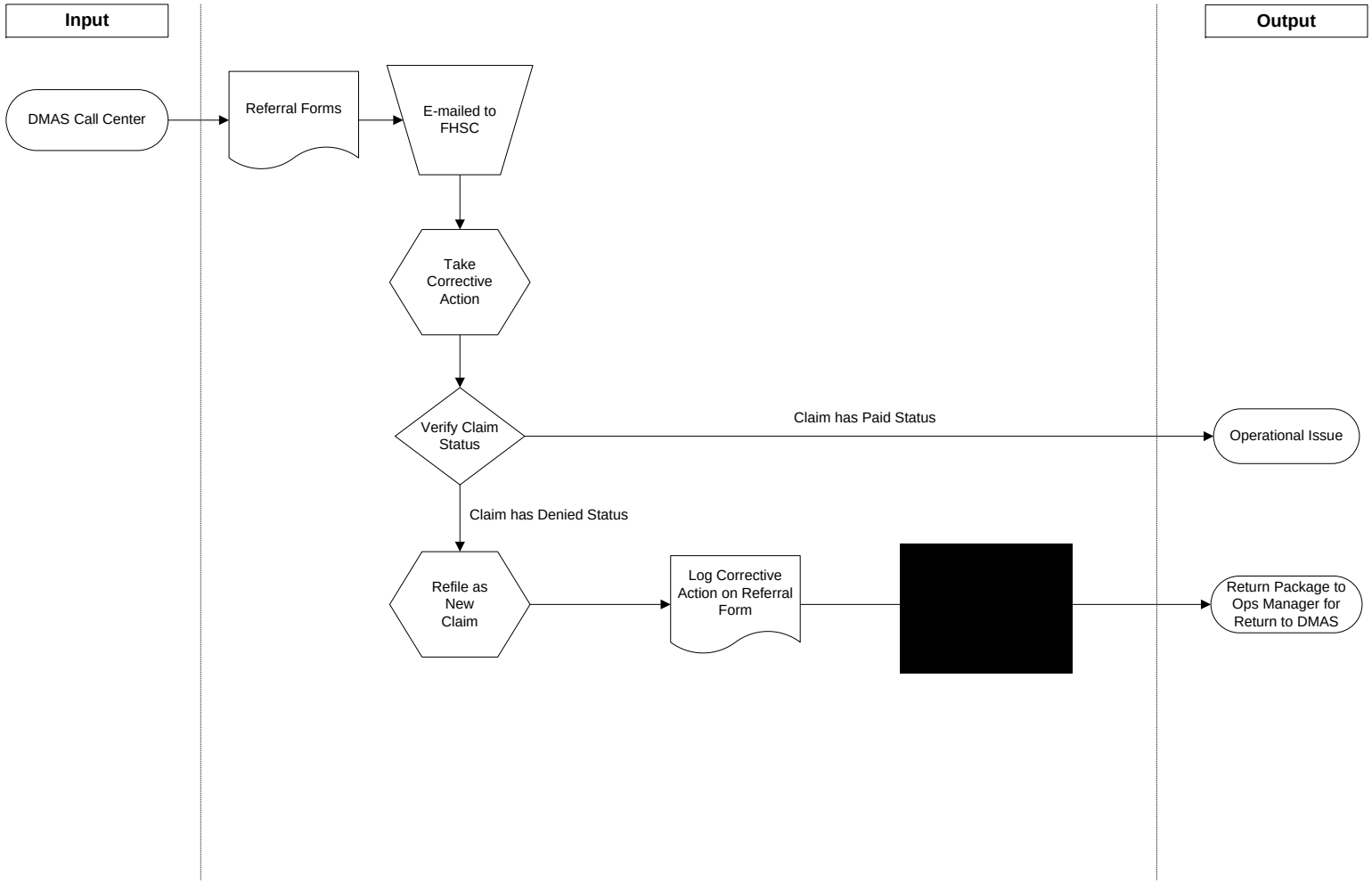
Figure 4.3.1 – Online Pend Resolution User Pend Location Screen CP-S-001-00

5.0 First Health Referral Forms

The DMAS Call Center will e-mail FHSC Referral Forms to VMAP. The referral form will request appropriate action be taken to research and adjudicate the claim. If the error is determined to be a Provider billing error, First Health will return the referral form to DMAS via e-mail after noting the corrective action on the form. The referral form and claim will be tracked on throughout the cycle. All of the action taken will be annotated on the referral form. The annotated referral form will be stored on [redacted].

WORKFLOW PROCESS

First Health Referral Forms



5.1 Receive and Process Referral Forms

Referral forms are e-mailed from the DMAS Helpdesk supervisors to this FHSC Department e-mail address: vafhscreferrals@fhsc.com. This e-mail address is only used to track referrals. This e-mail address is maintained by the Claims Manager and Supervisor. Each referral is submitted with a unique ticket number that allows for tracking of the referral.

Procedure

1. Check the vafhscreferrals@fhsc.com e-mail address mailbox daily for incoming mail.
2. Highlight all received e-mail envelopes.
3. Select *File, Print* to print all the selected envelopes.
4. Drag all of the highlighted envelopes to the **Checklist** folder.
5. Give the printed referrals to the Claims Supervisor.

5.2 Process First Health Referral Requests

Referral requests are processed daily at First Health. If the error being referred is a Provider billing error, First Health will return the referral form to DMAS after noting the corrective action on the form. DMAS will then contact the provider to request an adjustment or void. Claims personnel will take corrective action on the claim based on the referral reason and the claim status. When the corrective action is complete, only the referral ticket is returned to the DMAS sender.

Procedure

1. Determine if the referral form should be returned to DMAS for corrective action or if the correction should be done by First Health.
2. If the referral form should be returned to DMAS:
    - ❖ Write an explanation of the necessary corrective action in the form's **Corrective Action** block on the FHSC Referral Form.
    - ❖ Log the referral form out. Do this:
        - – Open the vafhscreferrals@fhsc.com e-mail address.
        - – Open the **Checklist** folder.
        - – Search the ticket number that is printed in the subject line of the email.
        - – Reply to the sender by double-clicking on the e-mail.
        - – Scroll down to the corrective action line.
        - – Key the reprocessed ICN on the appropriate line.

- Note all comments beside the words **Corrective Action.**
- Click the **Send** icon to reply to the e-mail sender.
- Close the e-mail.
- Click on the **Complete** box to indicate that the FHSC Referral ticket number is complete.

3. If the correction should be done by First Health:

   - Make a copy of the referral.
   - Forward this copy to the Imaging Technician for research and to log any errors that were caused by Data Capture operator.
   - Verify the claim's status using the **VaMMIS CHIRP** screens. Take the action listed in the table that begins below based on the claim status in CHIRP.

Status	Action
Paid	If the claim is in paid status, but can not be worked due to other operational issues like the system being maintained or fixed, put the referral aside until it can be worked.
Pended	If the claim can be adjusted or voided on-line, do this: 1. Review valid values for data element 2033. 2. Write the reason code that you will use to adjust or void the claim in the **RSN** field of the FHSC Referral Form. 3. Adjust or void the claim on the VaMMIS following the procedures in Section 6.1 and the On-line HELP for the **Adjustment Selection** screen (CP-S-003-02). 4. Write the system-generated ICN of the adjusted/voided claim in the New ICN field on the FHSC Referral Form. 5. Check the Corrective Action part of the form to make sure it is complete. 6. E-mail a copy of the completed form to DMAS sender. 7. Put the claim and documentation together. 8. Submit the package to Data Prep for scanning and storage on [redacted].
Denied	If the claim is in this status, it must be re-filed as a new claim. Do this: 1. Look at the claim attached to the referral form to see if it can be scanned. If it cannot be re-scanned, re-write the claim on a blank claim form. 2. Re-file the claim package. Include these items: – The re-written paper claim or the original claim. – All attachments – A screen copy of the CHIRP screen with all claim data. 3. If using the original claim, tape over the ICN printed on the claim and the ICN printed on all attachments. 4. On the referral form, log the corrective action being taken and the date that the claim is being sent to Data Prep.

Status	Action
	5. Complete the **First Health Data Prep Memorandum** form. **Note:** This form requests new ICNs for the claims that are being re-submitted for processing. A sample copy of the form is in Appendix E. 6. Put the First Health Memorandum and the claims to be reprocessed in a gray folder. 7. Forward this package to Data Prep for processing. 8. When the First Health Memorandum is returned from Data Prep, verify the claim's status using CHIRP. – Status 5 = To be paid. – Status 4 = Pending (to be resolved) – Status 1 = Paid – Status 3 = Denied (Check for a legitimate denial reason.) – Status 6 = To be denied 9. Sign and date the completed referral form. 10. E-mail a copy of the completed form to the DMAS sender.

6.0 Adjust or Void Individual Payment Requests

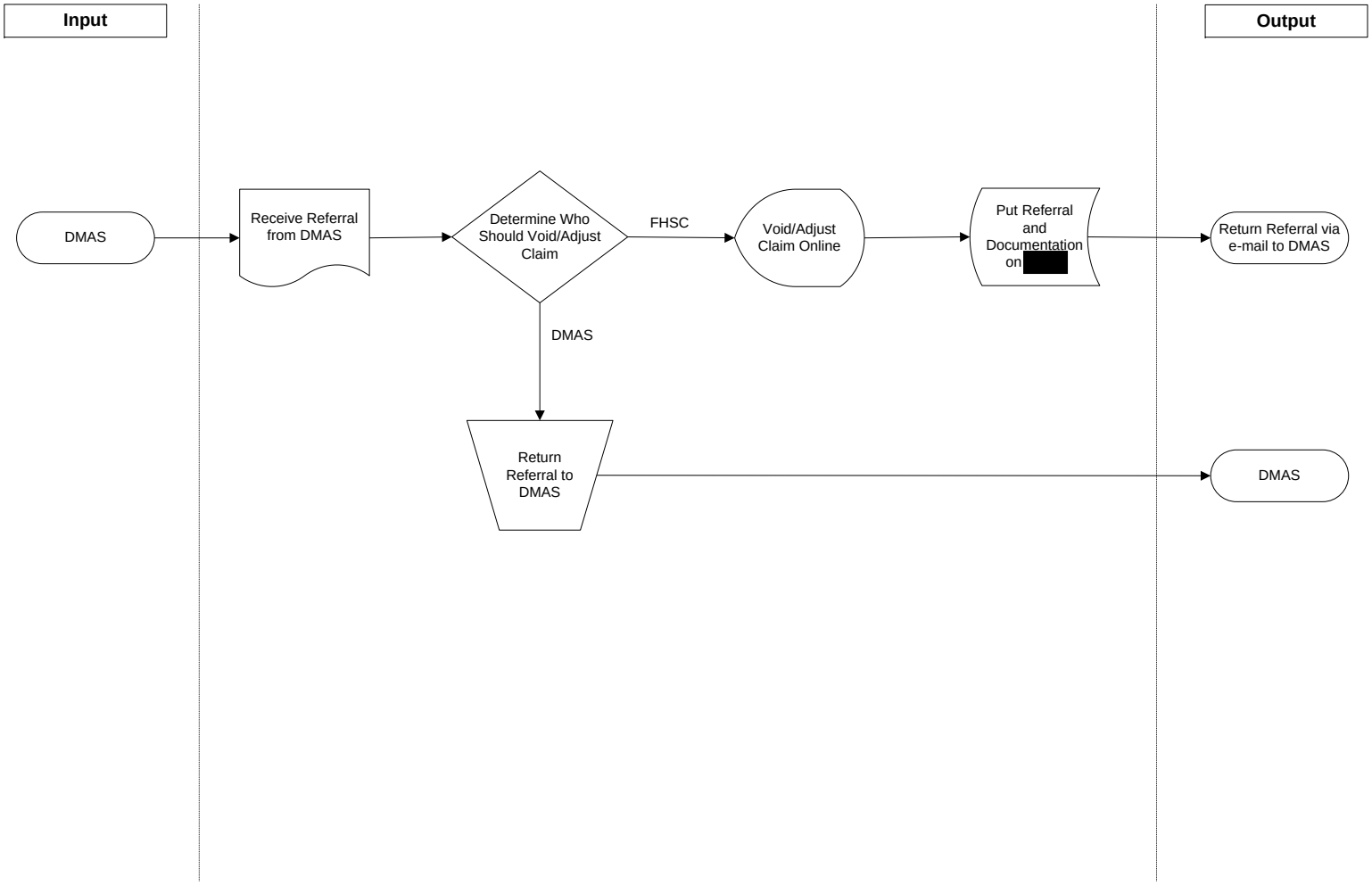
Adjusting/voiding individual payment requests is an on-line function that can only be done by a Claims Supervisor and one Claims Specialist.

Claims will only be adjusted or voided when First Health receives an FHSC Referral Form from DMAS or when a First Health pended claim requires that a conflicting claim be adjusted or voided. First Health will only adjust or void claims due to the improper processing on behalf of First Health. If the error is determined to be a provider billing error, First Health will return the FHSC Referral Form to DMAS. DMAS will then contact the provider to request a adjustment or void.

For auditing purposes, First Health will store all adjusted/voided claims and accompanying documentation on the [redacted] system. Adjusted/voided claims will be stored in the [redacted] web site in the VAMMIS INVOICES/XIMAGE folder. These claims will be listed by Provider ID and the system-generated ICN.

WORKFLOW PROCESS

Adjust or Void Individual Payment Requests



6.1 Adjust Individual Payment Requests

Payment requests can be adjusted on-line by a Claims Supervisor or claims specialist following the receipt of the standard FHSC Referral form. The work will be done on the VaMMIS and copies of the pended claim and referral form will be stored on [redacted].

Procedure

1. From the main **VaMMIS** screen, choose the **Invoice Processing Subsystem** button.
2. Select the **Adjustment** radio button in the **Select Function** box.
3. Choose *Enter*.
4. Enter an *X* in the **Function** box to indicate that the claim is being adjusted.
5. Enter the adjustment reason code.
6. Enter the ICN of the claim to be adjusted.
7. Choose the **Enter** button.
8. You see the **CHIRP (Adjust/Void)** detail screen for the ICN you entered.
9. Make a screen print of the screen before you make any adjustments.
10. Enter the data needed to adjust the claim.
11. Choose the **Enter** button to submit the data entered.
12. When all data entered passes the edits, make another screen print.
13. Choose the **Accept** button to adjudicate the claim or choose **Cancel** if you do not want to process the request.
14. If the adjusted claim pends, note the ICN and go to the **Pend** screen to work the pended claim.
15. Choose the **Exit** button to leave the program.
16. Attach both screen prints to the First Health Referral form and forward the package to the Data Preparation group for storage on [redacted].

6.2 Void Individual Payment Requests

A Claims Supervisor or claims specialist can void individual payment requests online using the VaMMIS. As with adjustments, copies of the voided claim and referral form will be stored on [redacted].

Procedure

1. From the main **VaMMIS** screen, choose the **Invoice Processing Subsystem** button.
2. Select the **Void** radio button in the **Select Function** box.
3. Choose *Enter*.
4. Enter an *X* in the function box to indicate that the claim is being voided.
5. Enter the void reason code.
6. Enter the ICN of the claim to be voided.
7. Choose the **Enter** button.
8. You see the **CHIRP (Adjust/Void)** detail screen for the ICN you entered.
9. Make a screen print of the screen before you make void the claim.
10. Look over the claim to make sure it is the claim you want to void
11. Choose **Enter** to verify the results of the void process, make another screen print.
12. Choose *Accept* to void the claim

    - OR -

    Choose *Cancel* to cancel the action.
13. Choose the Exit button to leave the program.
14. Attach both screen prints to the First Health Referral Form and forward the package to the Data Preparation group for storage on [redacted].

6.3 Adjust and/or Void Conflicting Claims

First Health will adjust or void claims when a First Health-pended claim requires that a conflicting claim be adjusted or voided. The actual adjust/void must be done by a Claims Supervisor or claims specialist.

Procedure

1. If the claim pends for edits 1108, 1012, or 0958, follow the procedures in the table below.

Edit	Action
1108	1. Look at the recipient's claims history screens for all other surgeries on the same date of service as the pended claim. 2. Pay the amount allowed for the procedure with the highest allowance. 3. Adjust all other surgeries by 50% using adjustment reason 1055.
1012	For procedure codes 99283, 99284, or 99285 (ER) pending against a history claim with

Edit	Action
	procedure code 93010, 93042, or Radiology (X-ray procedures beginning with a 7). 1. Override the edit and pay the pending claim. 2. Void the conflicting claim using void reason 1071.
958	If the conflicting claim was paid for the same procedure, and the conflicting claim was not a Title 18, void the conflicting claim using reason 1047.

2. Make a screen print of the pended and conflicting claims.
3. Sign both screen prints and paper clip them together.
4. Separate adjustments from voids.

The Claims Specialist will…

1. Adjust or void the claim as necessary in VaMMIS.
2. Complete an FHSC Referral Form for each adjustment or void.
3. Return the adjustment/void screen prints to a Claims Technician.

The Claims Technician will…

1. Resolve the claim using the adjusted ICN number.
2. Return all the screen prints to the Claims Specialist.

The Claims Specialist will…

1. Scan each documentation set for storage on [redacted].
2. File the scanned adjustment/void documentation sets in storage for 10 days.
3. Spot-check the XIA file on [redacted] to make sure the scanned documentation set is stored under the appropriate Julian date.

Note: Supervisor and claims specialist will monitor adjustment/void box daily and process claims.

Appendix A Aged Pend Reports

Reports in this Appendix		
Report Number	**Report Name**	**Page**
CP-O-053-01	Weekly Aged Pend List - ICN Sequence	60
CP-O-053-02	Weekly Aged Pend List - Provider, ICN, sequence	64
CP-O-406	Pended Claims Over 30 Days Old	68
CP-O-409-01	Aged Pended Claims with a Status of 4	71
CP-O-409-02	Aged Pended Claims with a Status of 7	74

Report Title	**Weekly Aged Pend List – ICN Sequence**
Description	This report lists in ICN order each claim that has a current pend status.
Output Number	CP-O-053-01
Frequency	Weekly
Output Form	Standard
Retention	30 Days
Distribution	Claims Contract Monitor (DMAS)
Sequence	Claim Type ICN
Control Breaks	Claim Type
Relationship to Other Reports	The user will use this report to monitor aged pends by ICN order by claim type.

CPR305
AS OF:MM/DD/CCYY
RUN DATE: MM/DD/CCYY HH:MM

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

WEEKLY AGED PEND LIST BY ICN

UNIT: 100-FIRST HEALTH CLAIMS RESO (EASY PENDS)

REPORT NO: CP-O-053-01
PAGE NUMBER: ZZ,ZZ9

(13)
CLAIM TYPE: XXXXXXXXXXXXXXXXXX

ICN NUMBER (1)	ENROLLEE ID (2)	ENROLLEE NAME (3) (3.1) (3.2)	PROVIDER NUMBER (4)	PROVIDER NAME (5)	FROM DATE (6)	CHARGES (7)	CLM MOD (8)	ERROR CNT (9)	ERR (10)	ST (11)	STATUS DATE (12)
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999

CLAIM TYPE: XXXXXXXXXXXXXXXXXX (13) TOTAL CLAIMS PENDED: ZZ,ZZZ,ZZ9 (14) TOTAL CHARGES: ZZZ,ZZZ,ZZ9.99 (15)

TOTAL PENDS FOR 100-FIRST HEALTH CLAIMS RESO (EASY PENDS) ZZ,ZZZ,ZZ9 (**16**)

*** END OF REPORT ***

Sample Weekly Aged Pend List – ICN Sequence
Output Number CP-O-053-01

Weekly Aged Pend List – ICN Sequence Output Number CP-O-053-01 Field Definitions			
Field #	**Field Name**	**VaMMIS DE #**	**Field Definition**
1	ICN Number	2001	Claim Request ICN A unique Transaction Control Number serving to identify each claim transaction record. It is the group representation of Claim Reference DMB (first fourteen Bytes representing the date, media, batch number, sequence number) and Claim Reference lines (last two bytes representing line number).
2	Enrollee ID	3093	Enrollee Permanent Identification Number The DMAS-administered identification number that is used to tie all claims for a single enrollee together. This is the ID number that is used as the key to access the Claims History File.
3	Enrollee Name (First)	3111	Enrollee First Name The first name of the individual eligible for a DMAS-administered medical care program.
3.1	Enrollee Name (Middle Initial)	3112	Enrollee Middle Initial The middle initial of the individual eligible for a DMAS-administered medical care program.
3.2	Enrollee Name (Last)	3110	Enrollee Last Name The last name of the individual eligible for a DMAS-administered medical care program.
4	Provider Number	4002	Provider Identification Number A unique identification number assigned to a provider.
5	Provider Name	4085	Provider Name The name of the provider. If a Business Type Provider Name, the field is 40 bytes free format. If an Individual Type Provider Name, the field is Last Name, First Name, Middle Initial, Suffix, and Title.
6	From Date	2010	Claim Service From Date Date on which the service was first rendered; for a claim covering only one service (e.g., a

Weekly Aged Pend List – ICN Sequence Output Number CP-O-053-01 Field Definitions			
Field #	**Field Name**	**VaMMIS DE #**	**Field Definition**
			prescription), this is the only service date.
7	Charges	2016	Claim Billed Charge The charge submitted on a claim.
8	Clm Mod	2003	Claim Type Modifier A code which indicates the type of claim transaction and the processing to be done. For paper claims, the third position of the transmission code is moved to this field. Use on-line Help system to find valid codes for this field.
9	Error Cnt	Calculated	Number of errors.
10	Err	5501	Error Text Error Code Code assigned to each edit error identified in the Claims Processing Subsystem Edit/Audit Manual.
11	St	2039	Claim Status Code indicating the status of a claim after an adjudication cycle. Use the on-line Help System to find valid codes for this field.
12	Status Date	2383	Claim Status Begin Date The date on which this status was assigned to the claim. It is essentially the claims activity date, which can be assigned by adjudication or financial cycles.
13	Claim Type	2002	Claim Type A code defining the type of claim. For paper claims, the first 2 positions of the transmission code are used to derive this field. Use the on-line Help system to find valid codes for this field.
14	Total Claims Pended	Calculated	Total claims pended.
15	Total Charges	Calculated	Total charges.

Report Title	**Weekly Aged Pend List – Provider, ICN Sequence**
Description	This report lists in provider, ICN order each claim that has a current pend status.
Output Number	CP-O-053-02
Frequency	Weekly
Output Form	Standard
Retention	30 Days
Distribution	Claims Contract Monitor (DMAS)
Sequence	Provider ICN
Control Breaks	Claim Type
Relationship to Other Reports	The user will use this report to monitor aged pends by provider and ICN order by claim type.

CPR305 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: CP-O-053-02
AS OF MM/DD/CCYY PAGE NO: ZZ,ZZ9
RUN DATE: MM/DD/CCYY HH:MM WEEKLY AGED PEND LIST

(13)
CLAIM TYPE: XXXXXXXXXXXXXXXXXX

ICN NUMBER (1)	ENROLLEE ID (2)	ENROLLEE NAME (3) (3.1) (3.2)	PROVIDER NUMBER (4)	PROVIDER NAME (5)	FROM DATE (6)	CHARGES (7)	CLM MOD (8)	ERROR CNT (9)	ERR (10)	ST (11)	STATUS DATE (12)
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999
9999999999999999	999-999999-99-9	XXXXXXXXXX X XXXXXXXXXXXXXXX	9999999999	XXXXXXXXXXXXXXXXXXXXXXXXX	99/99/9999	Z,ZZZ,ZZ9.99	X	999	999	X	99/99/9999

CLAIM TYPE: XXXXXXXXXXXXXXXXXX (13) TOTAL CLAIMS PENDED: ZZ,ZZZ,ZZ9 (14) TOTAL CHARGES: ZZZ,ZZZ,ZZ9.99 (15)

*** END OF REPORT ***

Sample Weekly Aged Pend List – Provider, ICN Sequence
Output Number CP-O-053-02

Weekly Aged Pend List – Provider, ICN Sequence Output Number CP-O-053-02 Field Definitions			
Field #	**Field Name**	**VaMMIS DE #**	**Field Definition**
1	ICN Number	2001	Claim Request ICN A unique Transaction Control Number serving to identify each claim transaction record. It is the group representation of Claim Reference DMB (first fourteen bytes representing the date, media, batch number, sequence number) and Claim Reference lines (last two bytes representing line number).
2	Enrollee ID	3093	Enrollee Permanent Identification Number The DMAS-administered identification number that is used to tie all claims for a single enrollee together. This is the ID number that is used as the key to access the Claims History File.
3	Enrollee Name (First)	3111	Enrollee First Name The first name of the individual eligible for a DMAS-administered medical care program.
3.1	Enrollee Name (Middle Initial)	3112	Enrollee Middle Initial The middle initial of the individual eligible for a DMAS-administered medical care program.
3.2	Enrollee Name (Last)	3110	Enrollee Last Name The last name of the individual eligible for a DMAS-administered medical care program.
4	Provider Number	4002	Provider Identification Number A unique identification number assigned to a provider.
5	Provider Name	4085	Provider Name The name of the provider. If a Business Type Provider Name, the field is 40 bytes free format. If an Individual Type Provider Name, the field is Last Name, First Name, Middle Initial, Suffix, and Title.
6	From Date	2010	Claim Service From Date Date on which the service was first rendered; for a claim covering only one service (e.g., a

Weekly Aged Pend List – Provider, ICN Sequence Output Number CP-O-053-02 Field Definitions			
Field #	**Field Name**	**VaMMIS DE #**	**Field Definition**
			prescription), this is the only service date.
7	Charges	2016	Claim Billed Charge The charge submitted on a claim.
8	Clm Mod	2003	Claim Type Modifier A code which indicates the type of claim transaction and the processing to be done. For paper claims, the third position of the transmission code is moved to this field. Use the on-line Help system to find valid codes for this field.
9	Error Cnt	Calculated	Number of errors.
10	Err	5501	Error Text Error Code Code assigned to each edit error identified in the Claims Processing Subsystem Edit/Audit Manual.
11	St	2039	Claim Status Code indicating the status of a claim after an adjudication cycle. Use the on-line Help System to find valid codes for this field.
12	Status Date	2383	Claim Status Begin Date The date on which this status was assigned to the claim. It is essentially the claims activity date, which can be assigned by adjudication or financial cycles.
13	Claim Type	2002	Claim Type A code defining the type of claim. For paper claims, the first 2 positions of the transmission code are used to derive this field. Use the on-line Help system to find valid codes for this field.
14	Total Claims Pended	Calculated	Total claims pended.
15	Total Charges	Calculated	Total charges.

Report Title	**Pended Claims Over 30 Days Old**
Description	This reports lists claims still pending after 60 days. These claims should be resolved before the 90 days purge.
Output Number	CP-0-406
Frequency	Weekly
Output Form	Standard
Retention	30 Days
Distribution	Claims Contract Monitor (DMAS)
Sequence	Invoice Type
Control Breaks	Invoice Type
Relationship to Other Reports	N/A

```
CPR305                                   VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES                          REPORT NO: CP-O-406
AS OF MM/DD/CCYY                                                                                                     PAGE NO:  ZZ,ZZ9
RUN DATE: MM/DD/CCYY  HH:MM                          PEND CLAIM LISTING BY AGE
                                                     PENDED CLAIMS 21-30 DAYS OLD
                                               999:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (9)

CLM                          PROVIDER    ENROLLEE         ACTIVITY     PEND   REASON                     PEND REASONS
TYPE        ICN              NUMBER      NUMBER           DATE         STAT   230 (*)   -- 1 ------- 2 ---------3--------4-------5-------6 ------ 7 -------8--------9
(1)         (2)              (3)         (4)              (5)          (6)    (7)                                          (8)
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
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 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999
 99  9999999999999999   9999999999  999-999999-99-9  MM/DD/CCYY    9      *      9999  9999  9999  9999  9999  9999  9999  9999  9999

                                                         *** END OF REPORT ***
```

Sample Pended Claims Over 30 Days Old
Output Number CP-O-406

Pended Claims Over 30 Days Old Output Number CP-O-406 Field Definitions			
Field #	**Field Name**	**VaMMIS DE #**	**Field Definition**
1	Clm Type	2002	Claim Type A code defining the type of claim. For paper claims, the first 2 positions of the transmission code are used to derive this field. Use the on-line Help system to find valid codes for this field.
2	ICN	2001	Claim Request ICN A unique Transaction Control Number serving to identify each claim transaction record. It is the group representation of Claim Reference DMB (first fourteen bytes representing the date, media, batch number, sequence number) and Claim Reference lines (last two bytes representing line number).
3	Provider Number	4002	Provider Identification Number A unique identification number assigned to a provider.
4	Enrollee Number	3093	Enrollee Permanent Identification Number The DMAS-administered identification number that is used to tie all claims for a single enrollee together. This is the ID number that is used as the key to access the Claims History File.
5	Activity Date	2383	Claim Status Begin Date The date on which this status was assigned to the claim. It is essentially the claim's activity date, which can be assigned by adjudication or financial cycles.
6	Pend Stat	2039	Claim Status Code indicating the status of a claim after an adjudication cycle. Use the on-line Help system to find valid codes for this field.
7	Reason 230 (*)	Calculated	Reason 230 (*)
8	Pend Reasons	5501	Error Text Error Code Code assigned to each edit error identified in the Claims Processing Subsystem Edit/Audit Manual.

Report Title	**Aged Pended Claims with a Status of 4**
Description	This report displays age of pends by invoice type, showing count of items 01-30 Days Old, 31-90 Days Old, and Over 90 Days Old, as well as overall totals by invoice type. Also, shows ICN of oldest pend on file for each invoice type. Gives statistics of claims with pend status of 4.
Output Number	CP-0-409-01
Frequency	Weekly
Output Form	Standard
Retention	30 Days
Distribution	Claims Contract Monitor (DMAS)
Sequence	N/A
Control Breaks	N/A
Relationship to Other Reports	N/A

CPR305 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: CP-O-409-01
AS OF MM/DD/CCYY PAGE NO: ZZ,ZZ9
RUN DATE: MM/DD/CCYY HH:MM

A-G-E O-F P-E-N-D
CLAIMS WITH A STATUS OF 4

CLAIM TYPE (1)	01 – 30 DAYS (2)	31 – 90 DAYS (3)	OVER 90 DAYS (4)	TOTAL PENDS (5)	AVERAGE AGE (6)	OLDEST PEND (7)	ICN OLDEST PEND (8)
01	99	99	999	999	99.99	999	9999999999999999
02	99	99	999	999	99.99	999	9999999999999999
03	99	99	999	999	99.99	999	9999999999999999
04	99	99	999	999	99.99	999	9999999999999999
05	99	99	999	999	99.99	999	9999999999999999
06	99	99	999	999	99.99	999	9999999999999999
08	99	99	999	999	99.99	999	9999999999999999
09	99	99	999	999	99.99	999	9999999999999999
10	99	99	999	999	99.99	999	9999999999999999
11	99	99	999	999	99.99	999	9999999999999999
13	99	99	999	999	99.99	999	9999999999999999
(9) TOTAL	999	999	999	999	99.99	999	9999999999999999

** Z9 ITEMS PENDED FOR REVIEW OF MEDICARE COVERAGE (REASON 230) AND (REASON 241) NOT INCLUDED IN ABOVE CALCULATION

*** END OF REPORT ***

Sample Aged Pended Claims with a Status of 4
Output Number CP-O-409-01

Aged Pended Claims with a Status of 4 Output Number CP-O-409-01 Field Definitions			
Field #	**Field Name**	**VaMMIS DE #**	**Field Definition**
1	Clm Type	2002	Claim Type A code defining the type of claim. For paper claims, the first 2 positions of the transmission code are used to derive this field. Use the on-line Help system to find valid codes for this field.
2	01-30 Days	Calculated	01-30 days
3	31-90 Days	Calculated	31-90 days
4	Over 90 Days	Calculated	Over 90 days
5	Total Pends	Calculated	Total pends
6	Average Age	Calculated	Average age
7	Oldest Pends	Calculated	Oldest pends
8	ICN Oldest Pend	2001	Claim Request ICN A unique Transaction Control Number serving to identify each claim transaction record. It is the group representation of Claim Reference DMB (first fourteen bytes representing the date, media, batch number, sequence number) and Claim Reference lines (last two bytes representing line number).
9	Total	Calculated	Total

Report Title	**Aged Pended Claims with a Status of 7**
Description	This report displays age of pends by invoice type, showing count of items 01-30 Days Old, 31-90 Days Old, and Over 90 Days Old, as well as overall totals by invoice type. Also, shows ICN of oldest pend on file for each invoice type. Gives statistics of claims with pend status of 7.
Output Number	CP-0-409-02
Frequency	Weekly
Output Form	Standard
Retention	30 Days
Distribution	Claims Contract Monitor (DMAS)
Sequence	N/A
Control Breaks	N/A
Relationship to Other Reports	N/A

CPR305 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: CP-O-409-02
AS OF MM/DD/CCYY PAGE NO: ZZ,ZZ9
RUN DATE: MM/DD/CCYY HH:MM

A-G-E O-F P-E-N-D
CLAIMS WITH A STATUS OF 7

CLAIM TYPE (1)	01 – 30 DAYS (2)	31 – 90 DAYS (3)	OVER 90 DAYS (4)	TOTAL PENDS (5)	AVERAGE AGE (6)	OLDEST PEND (7)	ICN OLDEST PEND (8)
01	99	99	999	999	99.99	999	9999999999999999
02	99	99	999	999	99.99	999	9999999999999999
03	99	99	999	999	99.99	999	9999999999999999
04	99	99	999	999	99.99	999	9999999999999999
05	99	99	999	999	99.99	999	9999999999999999
06	99	99	999	999	99.99	999	9999999999999999
08	99	99	999	999	99.99	999	9999999999999999
09	99	99	999	999	99.99	999	9999999999999999
10	99	99	999	999	99.99	999	9999999999999999
11	99	99	999	999	99.99	999	9999999999999999
13	99	99	999	999	99.99	999	9999999999999999
(9) TOTAL	999	999	999	999	99.99	999	9999999999999999

** Z9 ITEMS PENDED FOR REVIEW OF MEDICARE COVERAGE (REASON 230) AND (REASON 241) NOT INCLUDED IN ABOVE CALCULATION

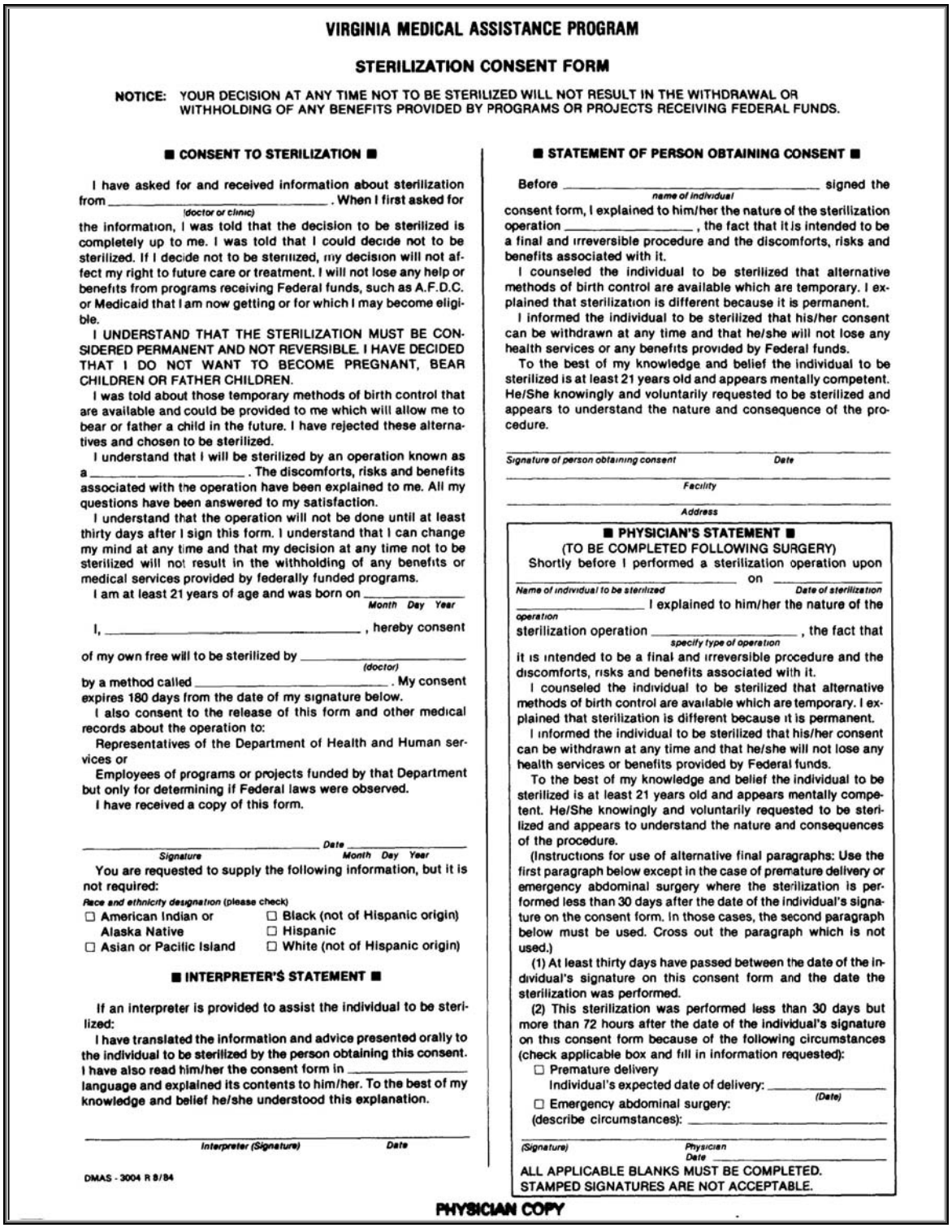
*** END OF REPORT ***

Sample Aged Pended Claims with a Status of 7
Output Number CP-O-409-02

Aged Pended Claims with a Status of 7 Output Number CP-O-409-02 Field Definitions			
Field #	**Field Name**	**VaMMIS DE #**	**Field Definition**
1	Clm Type	2002	Claim Type A code defining the type of claim. For paper claims, the first 2 positions of the transmission code are used to derive this field. Use the on-line Help system to find valid codes for this field.
2	01-30 Days	Calculated	01-30 days
3	31-90 Days	Calculated	31-90 days
4	Over 90 Days	Calculated	Over 90 days
5	Total Pends	Calculated	Total pends
6	Average Age	Calculated	Average age
7	Oldest Pends	Calculated	Oldest pends
8	ICN Oldest Pend	2001	Claim Request ICN A unique Transaction Control Number serving to identify each claim transaction record. It is the group representation of Claim Reference DMB (first fourteen bytes representing the date, media, batch number, sequence number) and Claim Reference lines (last two bytes representing line number).
9	Total	Calculated	Total

Appendix B Consent Forms

Forms in this Appendix		
Form Number	**Form Name**	**Page**
DMAS 3004	Sterilization Consent Form	79
DMAS 3005	Acknowledgement of Receipt of Hysterectomy Information Form	81
DMAS 3006	Abortion Certification	83



VIRGINIA MEDICAL ASSISTANCE PROGRAM

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent of my own free will to be sterilized by _____ (doctor) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

☐ American Indian or Alaska Native
☐ Asian or Pacific Island
☐ Black (not of Hispanic origin)
☐ Hispanic
☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ Interpreter (Signature) Date

DMAS - 3004 R 8/84

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ Signature of person obtaining consent Date

_____ Facility

_____ Address

■ PHYSICIAN'S STATEMENT ■

(TO BE COMPLETED FOLLOWING SURGERY)

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization) I explained to him/her the nature of the _____ (operation) sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Individual's expected date of delivery: _____ (Date)

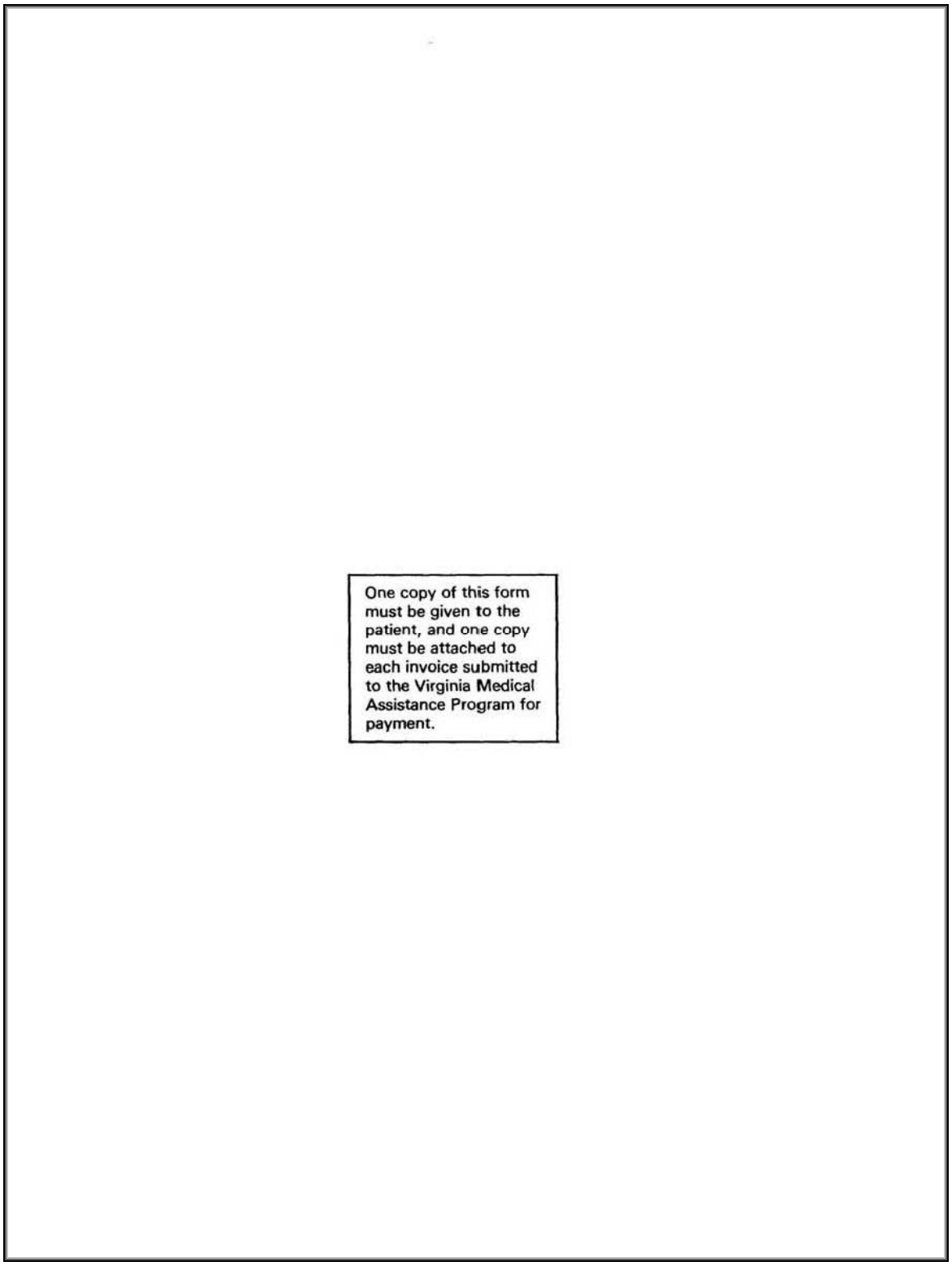
☐ Emergency abdominal surgery:
(describe circumstances): _____

_____ (Signature) Physician
Date _____

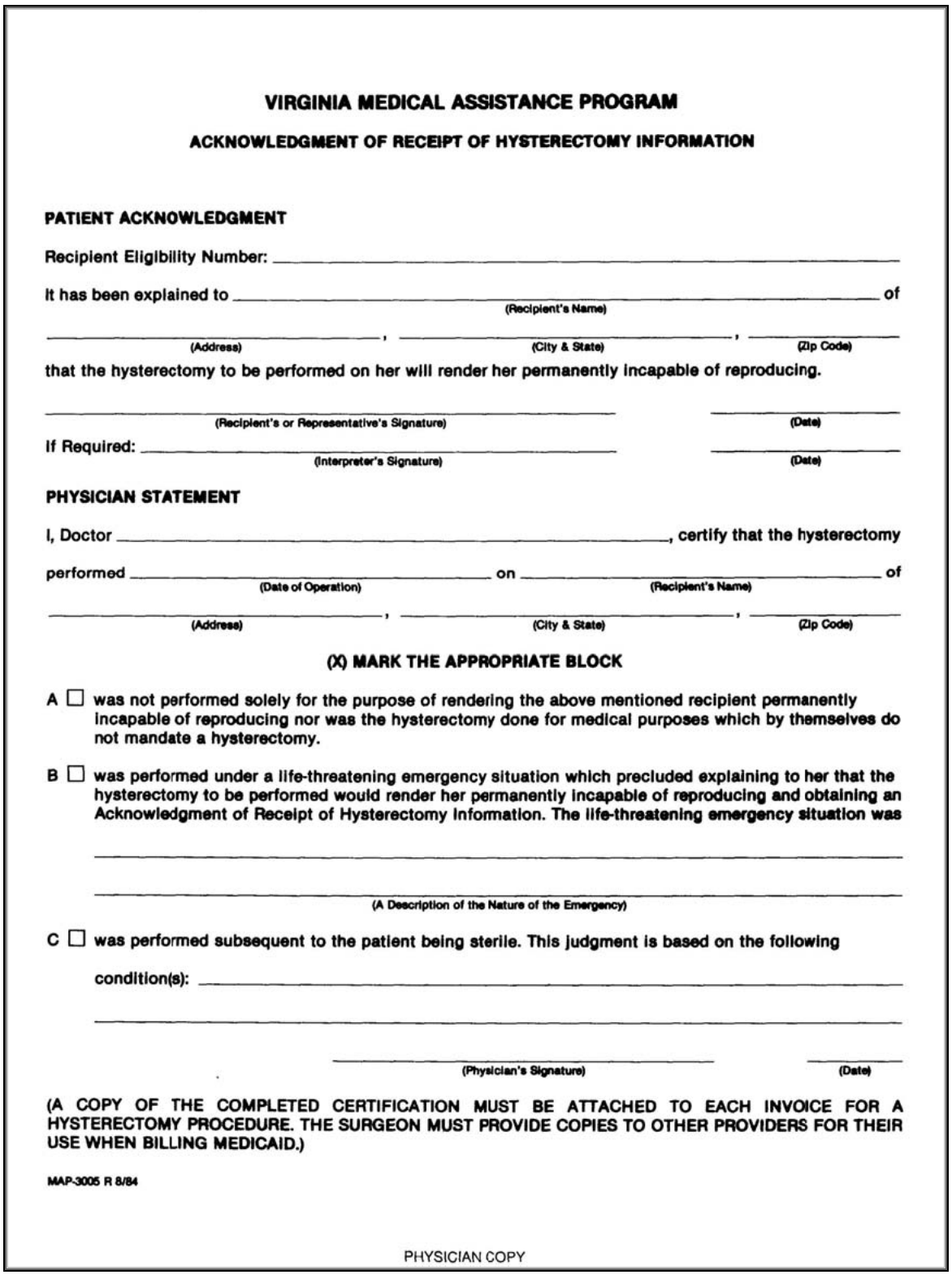
ALL APPLICABLE BLANKS MUST BE COMPLETED.
STAMPED SIGNATURES ARE NOT ACCEPTABLE.

PHYSICIAN COPY

DMAS 3004 – Sterilization Consent Form - front



DMAS 3004 – Sterilization Consent Form - back



VIRGINIA MEDICAL ASSISTANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PATIENT ACKNOWLEDGMENT

Recipient Eligibility Number: _____

It has been explained to _____ of
(Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

that the hysterectomy to be performed on her will render her permanently incapable of reproducing.

_____ _____
(Recipient's or Representative's Signature) (Date)

If Required: _____ _____
(Interpreter's Signature) (Date)

PHYSICIAN STATEMENT

I, Doctor _____, certify that the hysterectomy

performed _____ on _____ of
(Date of Operation) (Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

(X) MARK THE APPROPRIATE BLOCK

A ☐ was not performed solely for the purpose of rendering the above mentioned recipient permanently incapable of reproducing nor was the hysterectomy done for medical purposes which by themselves do not mandate a hysterectomy.

B ☐ was performed under a life-threatening emergency situation which precluded explaining to her that the hysterectomy to be performed would render her permanently incapable of reproducing and obtaining an Acknowledgment of Receipt of Hysterectomy Information. The life-threatening emergency situation was

_____

_____
(A Description of the Nature of the Emergency)

C ☐ was performed subsequent to the patient being sterile. This judgment is based on the following

condition(s): _____

_____

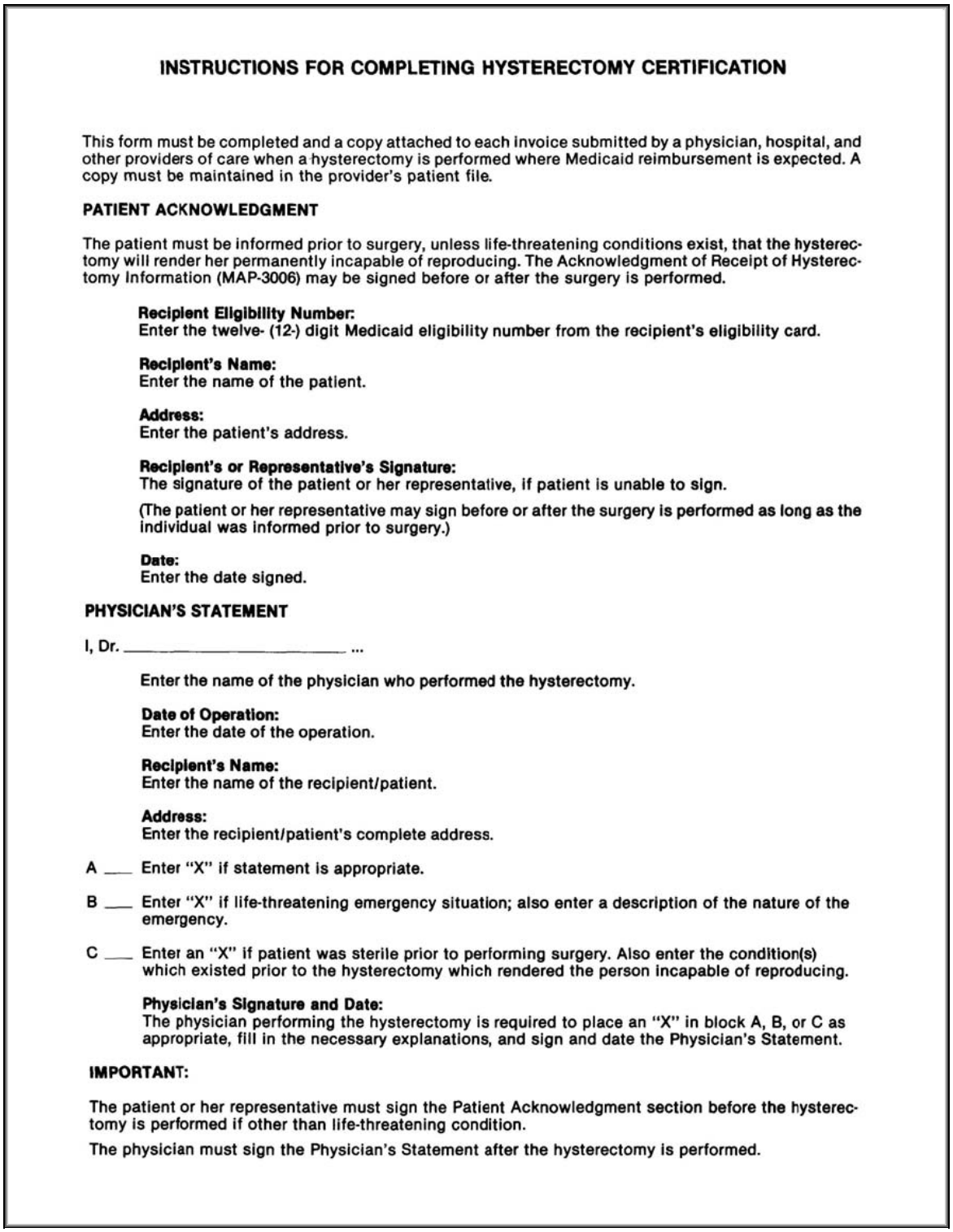
_____ _____
(Physician's Signature) (Date)

(A COPY OF THE COMPLETED CERTIFICATION MUST BE ATTACHED TO EACH INVOICE FOR A HYSTERECTOMY PROCEDURE. THE SURGEON MUST PROVIDE COPIES TO OTHER PROVIDERS FOR THEIR USE WHEN BILLING MEDICAID.)

MAP-3005 R 8/84

PHYSICIAN COPY

DMAS 3005 – Acknowledgement of Receipt of Hysterectomy Information Form - front



INSTRUCTIONS FOR COMPLETING HYSTERECTOMY CERTIFICATION

This form must be completed and a copy attached to each invoice submitted by a physician, hospital, and other providers of care when a hysterectomy is performed where Medicaid reimbursement is expected. A copy must be maintained in the provider's patient file.

PATIENT ACKNOWLEDGMENT

The patient must be informed prior to surgery, unless life-threatening conditions exist, that the hysterectomy will render her permanently incapable of reproducing. The Acknowledgment of Receipt of Hysterectomy Information (MAP-3006) may be signed before or after the surgery is performed.

Recipient Eligibility Number:
Enter the twelve- (12-) digit Medicaid eligibility number from the recipient's eligibility card.

Recipient's Name:
Enter the name of the patient.

Address:
Enter the patient's address.

Recipient's or Representative's Signature:
The signature of the patient or her representative, if patient is unable to sign.

(The patient or her representative may sign before or after the surgery is performed as long as the individual was informed prior to surgery.)

Date:
Enter the date signed.

PHYSICIAN'S STATEMENT

I, Dr. _____ ...

Enter the name of the physician who performed the hysterectomy.

Date of Operation:
Enter the date of the operation.

Recipient's Name:
Enter the name of the recipient/patient.

Address:
Enter the recipient/patient's complete address.

A ___ Enter "X" if statement is appropriate.

B ___ Enter "X" if life-threatening emergency situation; also enter a description of the nature of the emergency.

C ___ Enter an "X" if patient was sterile prior to performing surgery. Also enter the condition(s) which existed prior to the hysterectomy which rendered the person incapable of reproducing.

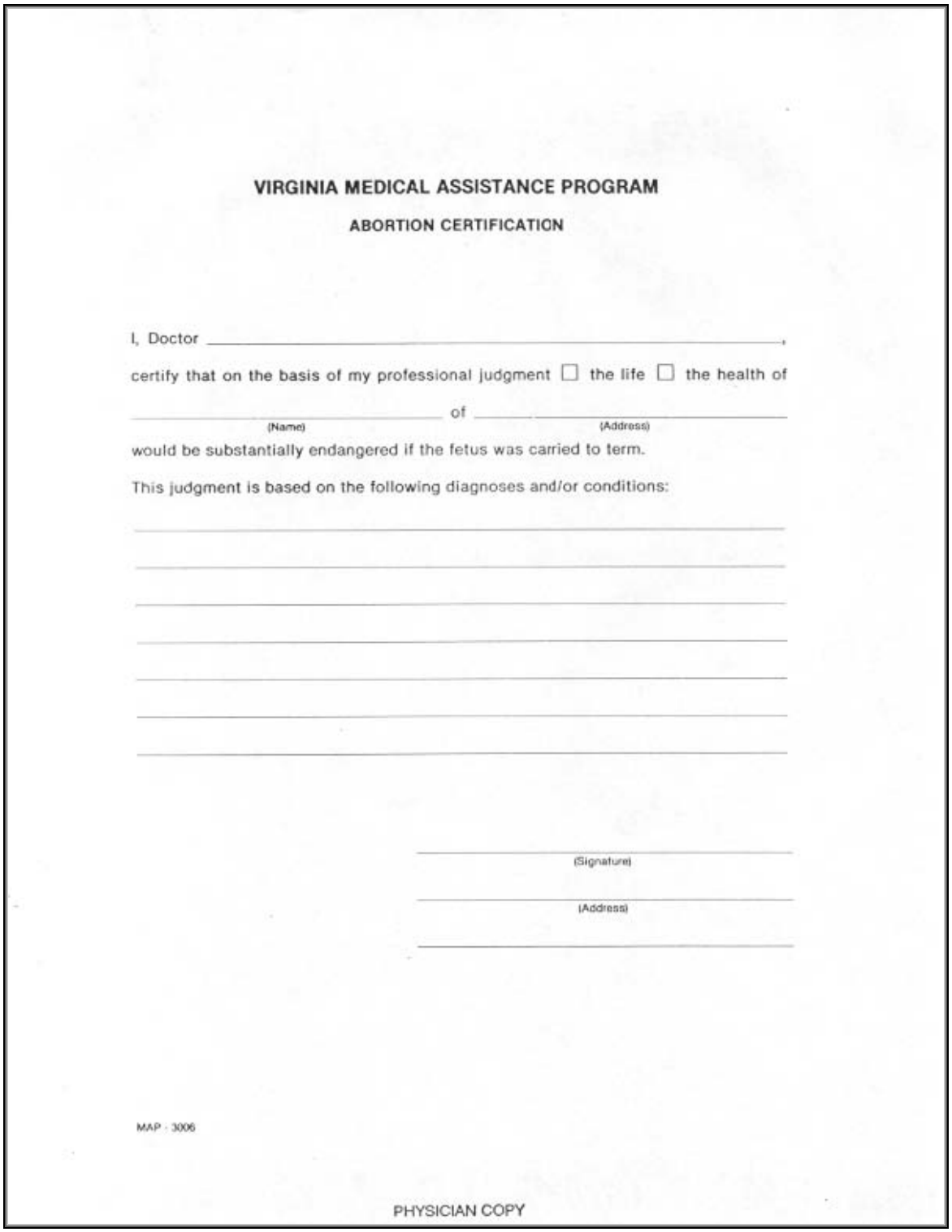
Physician's Signature and Date:
The physician performing the hysterectomy is required to place an "X" in block A, B, or C as appropriate, fill in the necessary explanations, and sign and date the Physician's Statement.

IMPORTANT:

The patient or her representative must sign the Patient Acknowledgment section before the hysterectomy is performed if other than life-threatening condition.

The physician must sign the Physician's Statement after the hysterectomy is performed.

DMAS 3005 – Acknowledgement of Receipt of Hysterectomy Information Form - back



VIRGINIA MEDICAL ASSISTANCE PROGRAM

ABORTION CERTIFICATION

I, Doctor _____,

certify that on the basis of my professional judgment ☐ the life ☐ the health of

_____ (Name) of _____ (Address)

would be substantially endangered if the fetus was carried to term.

This judgment is based on the following diagnoses and/or conditions:

_____

_____

_____

_____

_____

_____

_____

_____ (Signature)

_____ (Address)

_____

MAP - 3006

PHYSICIAN COPY

DMAS 3006 – Abortion Certification

Appendix C Required Forms

These forms are used in the Claims Resolution Process.

First Health Services Corporation
A Coventry Health Care Company

Pends Resubmitted Due To Data Capture Errors

Name:

Date	ICN	Block	Reason for 0098
Total			

Proprietary & Confidential
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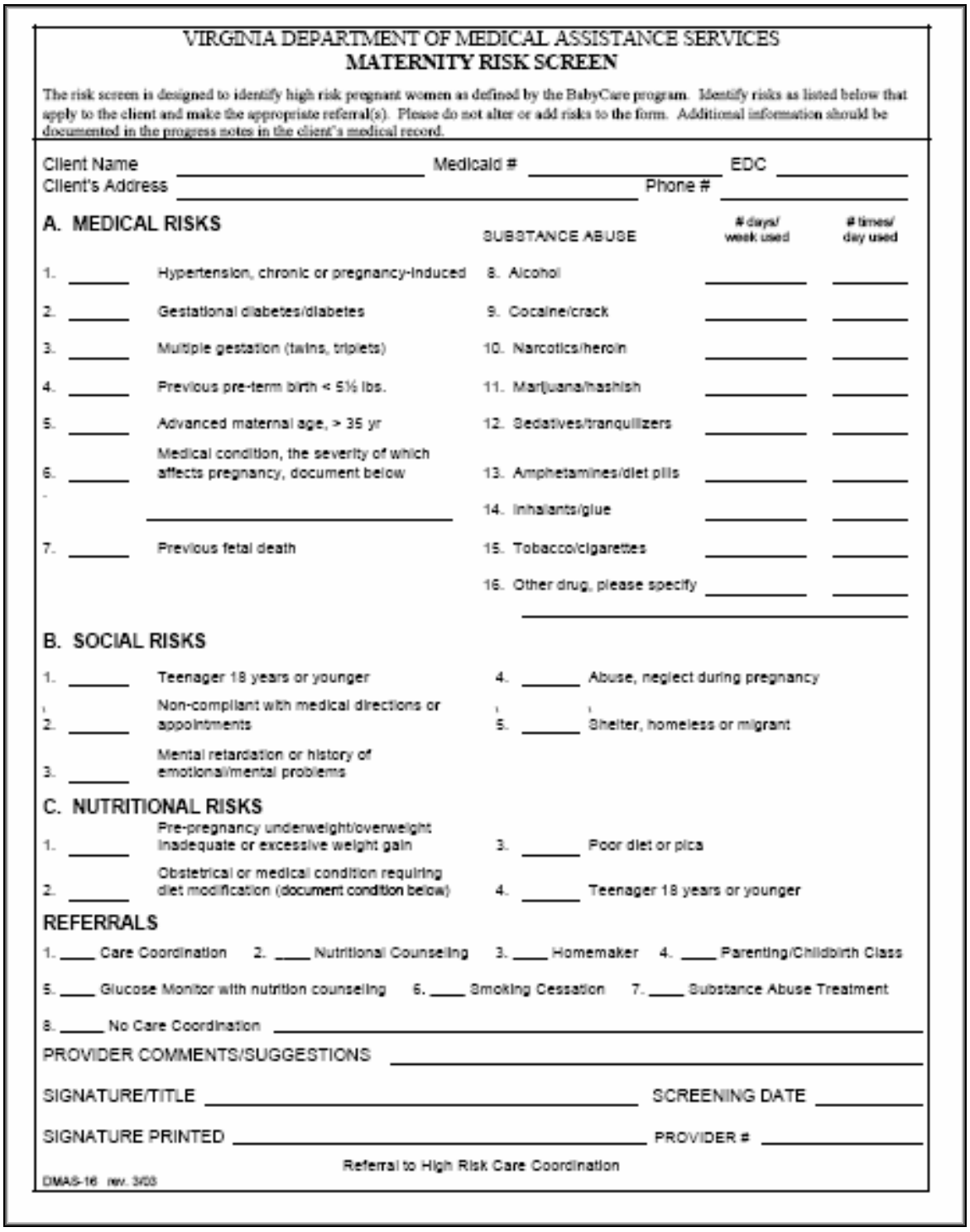
Pends Resubmitted Due to Data Capture Errors



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MATERNITY RISK SCREEN

The risk screen is designed to identify high risk pregnant women as defined by the BabyCare program. Identify risks as listed below that apply to the client and make the appropriate referral(s). Please do not alter or add risks to the form. Additional information should be documented in the progress notes in the client's medical record.

Client Name _____ Medicaid # _____ EDC _____

Client's Address _____ Phone # _____

A. MEDICAL RISKS

1. _____ Hypertension, chronic or pregnancy-induced
2. _____ Gestational diabetes/diabetes
3. _____ Multiple gestation (twins, triplets)
4. _____ Previous pre-term birth < 5½ lbs.
5. _____ Advanced maternal age, > 35 yr
6. _____ Medical condition, the severity of which affects pregnancy, document below
   _____
7. _____ Previous fetal death

SUBSTANCE ABUSE	# days/ week used	# times/ day used
8. Alcohol		
9. Cocaine/crack		
10. Narcotics/heroin		
11. Marijuana/hashish		
12. Sedatives/tranquilizers		
13. Amphetamines/diet pills		
14. Inhalants/glue		
15. Tobacco/cigarettes		
16. Other drug, please specify _____		

B. SOCIAL RISKS

1. _____ Teenager 18 years or younger
2. _____ Non-compliant with medical directions or appointments
3. _____ Mental retardation or history of emotional/mental problems
4. _____ Abuse, neglect during pregnancy
5. _____ Shelter, homeless or migrant

C. NUTRITIONAL RISKS

1. _____ Pre-pregnancy underweight/overweight inadequate or excessive weight gain
2. _____ Obstetrical or medical condition requiring diet modification (document condition below)
3. _____ Poor diet or pica
4. _____ Teenager 18 years or younger

REFERRALS

1. ____ Care Coordination 2. ____ Nutritional Counseling 3. ____ Homemaker 4. ____ Parenting/Childbirth Class

5. ____ Glucose Monitor with nutrition counseling 6. ____ Smoking Cessation 7. ____ Substance Abuse Treatment

8. _____ No Care Coordination _____

PROVIDER COMMENTS/SUGGESTIONS _____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PROVIDER # _____

Referral to High Risk Care Coordination

DMAS-16 rev. 3/03

Maternity Risk Screen

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

_____Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days)

_____

_____

_____See one time only for _____

_____See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter of your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

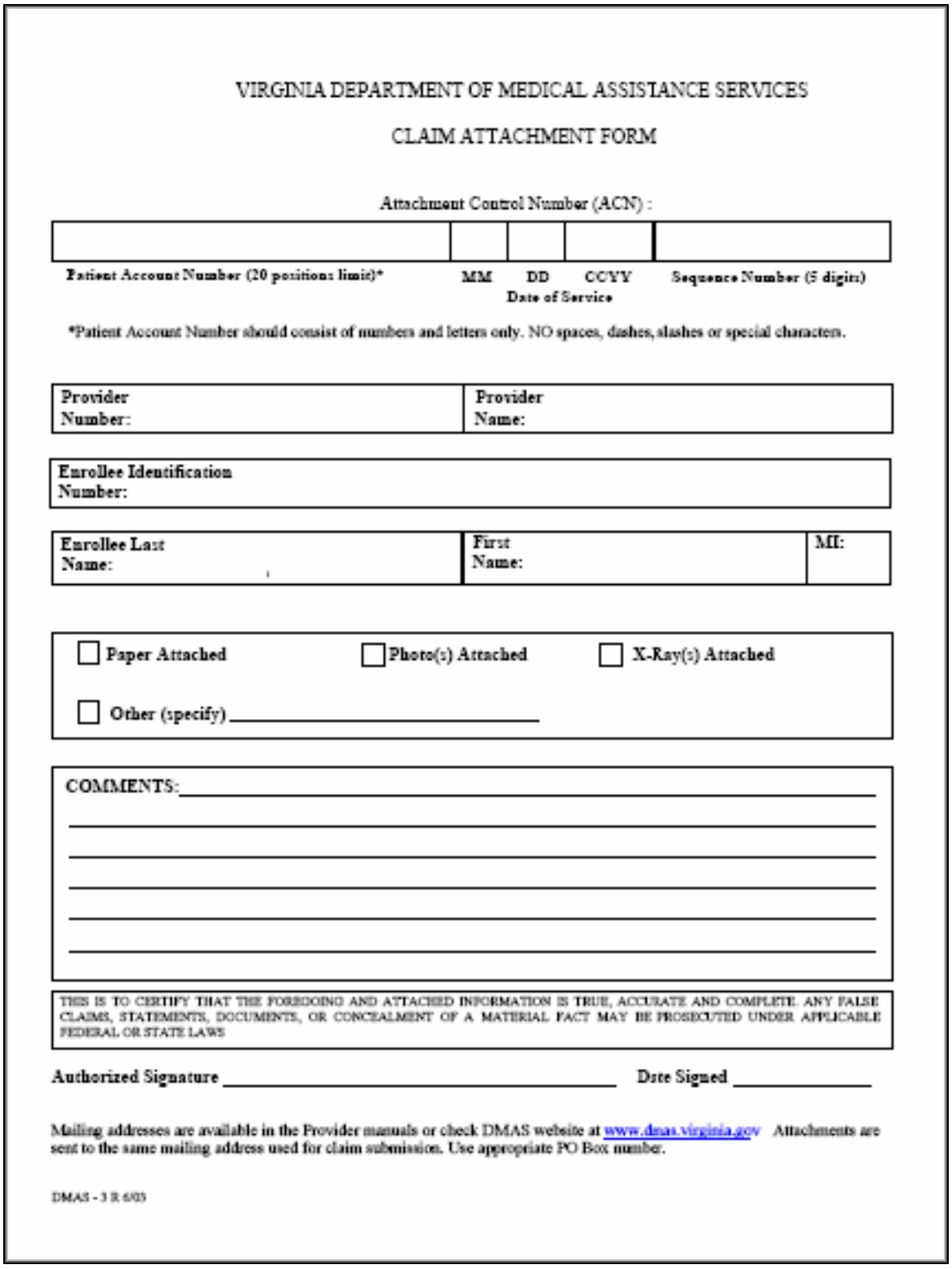
_____

_____

Telephone # (____)_____

DMAS-70 (5/06 REVISED)

Practitioner Referral Form



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	MM	DD	CCYY	Sequence Number (5 digits)
	Date of Service			

*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	Provider Name:

Enrollee Identification Number:

Enrollee Last Name:	First Name:	MI:

☐ Paper Attached ☐ Photo(s) Attached ☐ X-Ray(s) Attached

☐ Other (specify) _____

COMMENTS: _____

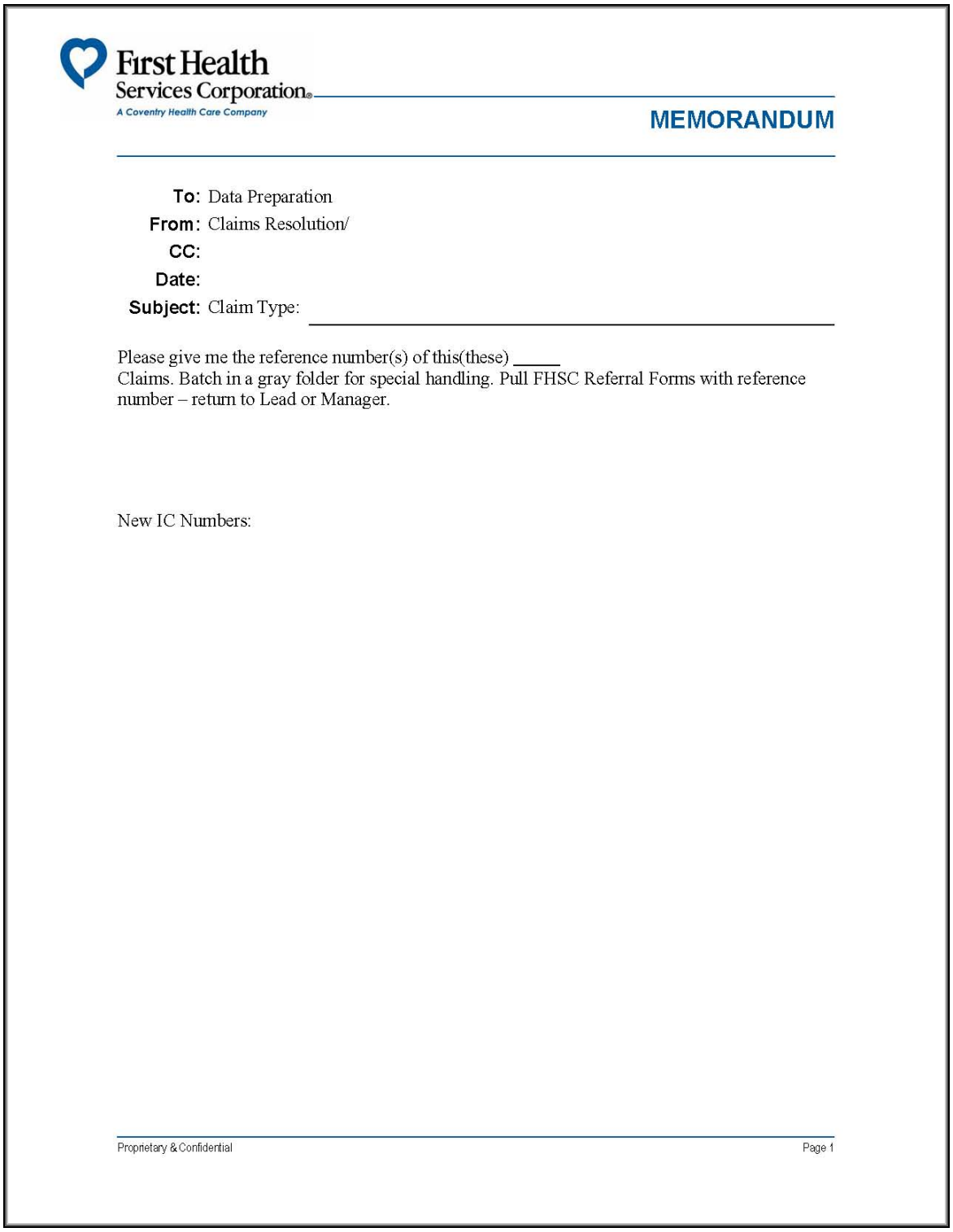
THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

Authorized Signature _____ Date Signed _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.virginia.gov Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS - 3 R 6/03

Claim Attachment Form



First Health Services Corporation
A Coventry Health Care Company

MEMORANDUM

To: Data Preparation
From: Claims Resolution/
CC:
Date:
Subject: Claim Type: _____

Please give me the reference number(s) of this(these) _____
Claims. Batch in a gray folder for special handling. Pull FHSC Referral Forms with reference number – return to Lead or Manager.

New IC Numbers:

Proprietary & Confidential Page 1

Data Prep Memorandum

Tracking # _____

FHSC REFERRAL FORM

Date: _____

To: Data Entry Manager
From: DMAS Call Center or Customer Service Sup
Subject: Scanning Error(s)

FHSC INDEXING USE ONLY
Claim Adjusted Online:
New ICN _____
Provider # _____

Referred By: _____
Name of caller: _____ Phone# _____

Please take the appropriate corrective action regarding the adjudication of the attached claims(s):

Invoice Type _____ Service Dates _____
Provider # _____ ICN# _____
Recipient ID#

Fields of Error(s).
_____
_____
_____
_____

FHSC ONLY - Please complete the following: (It is not necessary to return the incorrect or corrected copy of the claim.)

Corrective Action

Paper Claim Refiled:
New ICN: _____

Claim Adjusted Online:
New ICN: _____ RSN Code _____

Claim Voided Online:
New ICN: _____ RSN Code _____

Comments
_____
_____
_____

Signature of Person Submitting Correction: _____

Date Submitted to Data Entry: _____

Date Returned to DMAS: _____

PLEASE RETURN WITHIN 10 DAYS

FHSC Referral Form